VERIFICATION OF INSURANCE BENEFITS

Patient: _____ SS#:_____ DOB:_____
Guarantor: _____ DOB: _____
Chief Complaint: _____ Date of Onset: _____

1. This is to verify coverage as stated by_____ on _____
2. Effective date of coverage _____ Benefit period _____
3. What type of plan? (HMO,PPO,POS) _____Is There a HSA Act.?_____

What are the *Chiropractic* benefits and are they subject to deductible and co-pay?

4. What is the deductible? _____ Annual? _____
5. Is there a co-pay? _____ Amount? _____
6. Is the co-pay paid separate from the Patient's % due per Treatment?_____
7. **Is there a visit limit per year?**_____
8. **What is the $ amount limit on cmt /per visit?_____**

What are the *PT* benefits and are they subject to deductible and co-pay?

9.. What is the deductible? _____ Annual? _____
10. Is there a co-pay? _____ Amount? _____
11. Are these covered when done by Chiropractor: CPT Code: **97035____**, **97014____**, 97530___, **97110____**, 97112___, **97012_____**, , G0283
12. **Is there PT visit limit per year?**_____
13. **What is the $ amount limit on PT /per visit?**_____
    CPT Code: **L3020 (Orthotics**) Coverage:_____
    What are the **$ & Pair Limits/Restrictions**:_____
14. Are Physical Therapy Benefits the same as Chiropractic Benefits when billed out of Chiropractic office. _____
15. What is the Insurance payer ID#?_____ Billing Address?_____
16. Any pre/treatment pre-certification necessary_____
17. Any pre-certification necessary after certain number visits_____No#/Visits