43059 Seven Mile Road · Northville, MI 48167 · 248.449.1630 · Fax 248.449.1558

CHIROPRACTIC INSURANCE VERIFICATION

Our office is set up to utilize direct payment from insurance companies. This is done as a service to our patients and there is no charge for this service. However, it is important that you understand that health and accident insurance policies are an arrangement between you and your company. You are personally responsible for all service charges incurred in our office. We expect payment in full when services are rendered.

Patients name_____

Please fill out this form and return it to our office at your next visit. **HERE IS WHAT YOU DO TO VERIFY COVERAGE FOR CHIROPRACTIC CARE:**

DATE you called your insurance company_____

NAME of the person who gave you information _____Job Title_____

1. **CALL** your insurance company and ask the following questions:
   a. Does my policy cover Chiropractic? ___Yes ___No
      If yes, are there limits to my coverage? ___Yes ___No
      What are those limits? (Be as specific as possible): _____
      Will they cover **Cervical Supports**? ___Yes ___No **Spinal Traction**? ___Yes ___No
      Nutritional Supplements? ___Yes ___No **Structural Supports**? ___Yes ___No
      Is there a limit to the number of visits allowable? ___Yes ___No If yes, how many?____
   b. What is the **DEDUCTIBLE?**_____ Is that yearly? _____
      Has it been paid? ___Yes ___No If yes, how much? _____
      Is there a **FAMILY** deductible? ___Yes ___No How much? _____
      Is there a carry-over? ___Yes ___No How long? _____
   c. What percentage of my bills will my policy cover? _____
   d. What is the **effective date** of my policy? _____
   e. Can benefits be assigned to my chiropractor's office? _____
   f. What is the address of the office where the claims are sent? _____
      _____
   g. To whose **attention** is claim sent? _____
   h. **PHONE NUMBER** of insurance company_____
   i. **POLICY NUMBER**_____
      Individual policy? ____Yes ___No Group policy? ___Yes ___No
      Name policy is under_____
   j. Please check the one that applies to your case:
      ____Major Medical ____Personal injury ___Industrial accident/ worker's compensation
      ____Auto Accident
2. Obtain Insurance form from your agent or place of employment. Fill in the required personal information. Where applicable, have your employer fill in the indicated section then bring the form to our office. This questionnaire and your insurance form should be brought to our office within two weeks of your first visit. Once your coverage is confirmed we may accept payment directly from the insurance company.
3. If you have any questions or problems, please direct them to the office staff.

The above statements and answers are true,

_____

Patient's Signature