

## INSURANCE VERIFICATION FORM

Your Name (printed): \_\_\_\_\_ Date: \_\_\_\_\_

You will need the following information when calling your insurance company:

1) Insurance company's phone number (on the back of your card): \_\_\_\_\_

2) Policy holders name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please obtain and verify the following information. This will help you when deciding when/if to submit claims for reimbursement. \*Tip: it will also be helpful while you have an agent on the phone to ask what the process is for you to submit a claim yourself so that you are prepared.

1. Ask for the name of the person giving you this information: \_\_\_\_\_

2. Ask if you have chiropractic coverage for "out of network" providers.

If yes, please continue to verify type and amount of coverage

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A. What is the yearly deductible: Per Person: \_\_\_\_\_ Per Family: \_\_\_\_\_

B. How much of the deductible has been met this year: \_\_\_\_\_

C. What is the effective date of your policy: \_\_\_\_\_

D. Policy holder's employer: \_\_\_\_\_ ID# \_\_\_\_\_

Group # (if applicable to your policy): \_\_\_\_\_

E. **Name and address** of the insurance office where the claims are sent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for obtaining and verifying this information with your insurance company. By providing us with this information, we will be able to customize your detailed superbill for you to submit.

We offer three options for these statements, *please circle your preferred choice*:

Monthly | Quarterly | Yearly

## **ACTIVE HEALTH CHIROPRACTIC**

### **INSURANCE INFORMATION**

Insurance is a contract between the insured (patient) and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process. We have learned, over the past several years that the insured (patient) is the only one to whom the insurance company **must** give accurate plan information. It is for that reason that we ask you, the insured (patient), to complete this "Insurance Verification Form", (as explained below).

*Please read the following information to clarify insurance procedures.*

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are **not required** to cover chiropractic services. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer. If you have an insurance plan that reimburses for chiropractic care in this office, you must verify the type and amount of coverage before you can submit claims.

On the reverse side of this form is an "Insurance Verification Form" that will assist you in obtaining all the vital information needed for you to be able to submit statements to your insurance.

Please understand that you are responsible to pay for all services rendered at time of service, and that your insurance will reimburse you directly depending on your plan details once you've submitted your claims.

**I HAVE READ, UNDERSTAND AND AGREE TO COMPLETE ALL FORMS NECESSARY.**

**I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR SERVICES RENDERED TO ME, BUT THAT ACTIVE HEALTH CHIROPRACTIC WILL PROVIDE ME WITH DETAILED SUPERBILL NEEDED SO I CAN SUBMIT TO MY INSURANCE.**

Patient Name Printed: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_