# Insurance Verification Information

Copy of Insurance Card (Front and Back): Date Copied ___/___/___

**Patient Information**

Name _____ D.O.B ___/___/_____ Sex: M or F

S.S. # _____ Patient home phone #_____

Patient address_____

**Insured's Information**

Name _____ D.O.B ___/___/_____ Sex: M or F

S.S. # _____ Relationship to Patient: _____

**Insurance Information**

Company Name _____ Phone _____

Billing Address _____

Policy # _____ Group # _____

**Verification**

Date ___/___/___ Representative's Name _____

*"This is ….. I am calling to verify patient **out-of-network chiropractic** care benefits please"*

Effective Date ___/___/_____

Deductible $_____ Is it met? Yes No How Much? _____

% of coverage per visit _____ OR $ coverage per visit _____

Max. Number of visits _____ per _____ # of covered visits left to date _____

Max. Dollar Amount _____ per _____ Coverable $ left to date _____

Coverage amount of initial visit _____

Limitations of Care _____