

Thalman Chiropractic -- Insurance Verification Sheet

Hello! We are delighted you have chosen us for your chiropractic care. If you would like to utilize the benefits of your insurance policy, we ask that you review this form and call your insurance company prior to your first appointment to verify your coverage. We are happy to provide a copy of this form to assist you when you call. Please note that filing insurance is a courtesy we extend to all new patients, however it is your responsibility to know the coverage and benefits of your policy. If you have secondary insurance, please repeat this process for each plan.

When you arrive to our office for your first visit, please present your insurance card(s), photo identification, and the completed pre-appointment forms. If you have any questions, just give us a call at (618) 549-8228. Thank you and we look forward to seeing you soon!

Insurance Claim Type: INS / BCBS PPO / BCBS STATE GRP PLN/ HMO / MEDICARE/CAID / PI / WC / OTHER _____

Today's Date: _____ Time: ____ : ____ AM PM Insurance Rep Name: _____

Patient Name: _____ D.O.B.: _____

Policyholder: _____ Relationship to Patient: _____

Insurance Co.: _____ Insurance Customer Service Phone # (on Card): _____

Insured's Policy I.D. #: _____ Group #: _____ Insurance Mailing Address/Payor#: _____

"Hi, this is _____ and I am calling to verify my/ _____'s chiropractic coverage."

1. Plan Effective Date: _____ ... In-Network OR Out-of-Network ... Primary OR Secondary Plan

2. Is Chiropractic covered NO YES

3. Is there a deductible? NO YES Amount? _____
If yes, has it been met? YES NO Remaining Amount? _____

4. Is there a co-pay? NO YES Amount? _____ Is there a co-insurance? NO YES % _____

5. What are the benefit maximums:

Annual OR Visit Maximum Benefit Payable? Amount _____
Maximum # of visits per year? Fiscal OR Calendar # _____ # remaining? _____
Maximum Out of Pocket? Amount _____

6. Are the following treatments or modalities covered and at what percent?

Spinal Manipulation _____%

X-rays _____%

Office Visits/Exams _____%

Other Modalities/Treatments _____%

Physical/Rehabilitative Therapy BY A CHIROPRACTOR _____%

Massage BY A CHIROPRACTOR _____%

Braces, Supports & Custom-Fitted Orthotics _____%

7. Is pre-authorization required for any procedures including chiropractic or MRI/imaging? YES NO

I understand that the above information was obtained directly from my insurance company and they have explained that it is not a guarantee of benefits or payment. This office has suggested that I personally call my insurance company to verify my benefits as well, since this will enable me to understand my own benefits better. As a courtesy, this office will file my insurance at no additional charge and this office will cooperate with any additional, reasonable requests by my insurance company. **I understand that my insurance coverage is a contract between me and my insurance company and that I will be responsible for any and all charges not paid by my insurance company.**

Signature of Patient

Signature of Office Manager