CHIROPRACTIC INSURANCE VERIFICATION

W/C ___ P/I ___ Health ___

Patient's Name: _____ SS#: _____-_____-_____

HEALTH INSURANCE:

Insured: _____ SS#:_____-_____-_____

Name of Insurance: _____ Phone#:_____
Billing Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #:_____ Effective: _____

Employed By: _____

Chiropractic: ___Y / N___ Deductible Amount _____ Has it been met?__Y / N__

Limits: $ amount max: _____ Amt/visit: _____ # of Visit: _____ Exclusions: _____

Vitamins: _____ Herbs: _____ Supports/Braces: _____ Orthotics: _____

Spoke with: _____ Date: _____

AUTO INSURANCE (MED PAY):

Insured: _____ SS#: _____-_____-_____

Name of Insurance: _____ Phone#:_____

Billing Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Claim #:_____ Effective: _____

Employed By: _____

Adjuster: _____ Date: _____

WORKER'S COMPENSATION:

Name of Insurance: _____ Phone#:_____

Billing Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____ WCAB #:_____ DOI: _____

Employer: _____

Adjuster Name: _____ Written Authorization?: Y / N Referred by: _____

Verification Done By: _____ Date: _____