



Pt. Name \_\_\_\_\_ Date \_\_\_\_\_

Phone Number \_\_\_\_\_ DOB \_\_\_\_\_

SS# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Phone Number \_\_\_\_\_

Claims Address \_\_\_\_\_

Named Insured \_\_\_\_\_

Relationship to Insured \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group \_\_\_\_\_

Effective Date \_\_\_\_\_ Payor ID \_\_\_\_\_

**Please ask the following questions to the insurance company:**

Calendar yr-Plan yr-Contract yr	<u>Chiro</u>	<u>PT</u>
1) Is there coverage for out-of-network benefits?	YES NO	YES NO
If yes, what percent is covered?	%_____	%_____
2) Amount of individual deductible?	\$_____	_____
Amount of family deductible?	\$_____	_____
3) How much of the deductible has been met?	\$_____	_____
Maximum number of yearly visits?	_____	_____
Maximum financial benefits per year?	_____	_____
4) Is prior authorization required for services?	YES	NO
Are there any pre-existing conditions?	YES	NO
5) Who did you speak to at the Insurance Company:		

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