# DR.ARLO GORDIN, DC

# INSURANCE VERIFICATION FORM (as affects any health insurance reimbursement for Chiropractic services)

Patient's Name: _____

Date of Birth:_____ Today's Date_____

**Please have the following information when calling your insurance company:**

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

2) Policy holders name (if different from patient):_____

**Calling your insurance you can verify the following information. It should give you the information on what reimbursement you may expect from them.**

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

1a. Date of this phone call to verify insurance benefits:_____

2. Ask if you have Chiropractic coverage for ***"out of network"*** providers. **If yes, please continue** to verify type and amount of coverage.

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 co-pay for Chiropractic visits: _____

D. Is there a limit to the number of visits or $ amount?: _____If yes, how many visits are allowed_____ and/or what is the $ limit?: _____

E. Are Chiropractic services limited by "Medical Necessity"?_____

F. How do I send in a receipt for my Chiropractic services for insurance reimbursement?_____

Requiring what forms or documents?_____

G. What is the effective date of the policy: _____

H. Policy holder's employer: _____ID#_____

Group # (if applicable to your policy):_____

**I. Name and address of the insurance office where the claims are sent and where I will send my paid receipts for Chiropractic services:**

_____

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