

Insurance Verification Form

We encourage all of our patients to verify their insurance benefits before and during their course of treatment. Doing so will help alleviate any questions or concerns you may have regarding your insurance policy and treatment coverage. We have developed the following guide to assist the process. Please call the customer service number on your insurance card.

Name: _____ SSN: ____ - ____ - ____

Primary Insurance: _____ Subscriber's Name: _____

ID#: _____ Group#: _____ Subscriber's DOB: ____/____/____

Secondary Insurance Company: _____ Subscriber's Name: _____

ID#: _____ Group#: _____ Subscriber's DOB: ____/____/____

Please contact a service representative and ask the following questions.

Name of Insurance Company Representative: _____ Date Spoken To: _____

Are these commonly recommended treatments covered?

Procedure	Procedure Code	
New Patient Examination	99201-99203	<input type="checkbox"/> Yes <input type="checkbox"/> No
Established Patient Examination	99211-99213	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spinal Manipulation	98940-98941	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extremity Manipulation	98943	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mechanical Traction	97012	<input type="checkbox"/> Yes <input type="checkbox"/> No
Therapeutic Exercise	97110	<input type="checkbox"/> Yes <input type="checkbox"/> No
Manual Therapy	97140	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is my provider covered/part of your network? Yes No- Ask next question.

Is there an out of network benefit? Yes No

Details: _____

Is there a deductible? Yes No

Amount of deductible: _____ Amount of deductible met: _____

Is the deductible based on a fiscal or a calendar year? Fiscal Calendar

If based on a fiscal year: _____ to _____

Date active: _____

How many treatments may I receive? _____

Is there a maximum allowable payment for each service? Yes No Amount: _____

What is my co-payment amount? _____

What is my co-insurance amount? _____

Is durable medical equipment covered? Yes No

Is there a separate deductible? Yes No Amount: _____

Do I need a primary care physician referral? Yes No

Is pre-certification needed? Yes No On what services: _____

Pre-certification point of contact: Phone: _____

Please fax this form to 518-357-3349 or bring completed form with you on your first scheduled appointment. If you have any questions concerning your benefits (or lack thereof), please contact us for assistance.