Medical Insurance Verification

Patient: _____ _____ Birthdate: ___/___/___
last name first middle init

SS#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Day phone _____

PRIMARY INSURANCE CARRIER

ID# _____ GRP #_____ EFF.DATE _____

Insurance Name _____ Phone ( ) _____

Address _____

Insured's Name _____ Relationship _____ DOB____
last name first

Employer's Name _____ SS # _____

SECONDARY CARRIER

ID# _____ GRP # _____ EFF.DATE _____

Insurance Name _____ Phone ( ) _____

Address _____

Insured's Name _____ Relationship_____ DOB_____
last name first

Employer's Name _____ SS# _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the part who accepts assignment. I understand insurance is not a guarentee of benefit payment and I remain fully responsible for all chiropractic costs regardless of insurance coverage.

X _____
Signature of Patient or Legal Guardian Date

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician for services rendered.

X _____
Sign Date

****

OFFICE USE ONLY IN MD OTHER

DEDUCTIBLE _____ MET? _____ = _____ COPAY _____ ** _____ **

ADJ _____

THERAPY _____ X-RAY _____ INT EXAM _____ REEVAL _____ SUPPORTS _____

BENEFITS MAILED DR / PT

_____