

**HEALTH INSURANCE QUESTIONNAIRE**

If you would like us to bill your insurance company directly please call your insurance company and return this completed questionnaire. You are fully responsible for all office fees until your insurance coverage is confirmed.

Patient name: \_\_\_\_\_ Insurance company name: \_\_\_\_\_

Insurance company's phone #: \_\_\_\_\_ Policy holder's name (insured): \_\_\_\_\_

Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_

Date insurance company called: \_\_\_\_\_ Name of insurance representative you spoke to: \_\_\_\_\_

Does your policy cover chiropractic? \_\_\_\_\_ **IF YES COMPLETE THE FOLLOWING:**

What is the effective date of your policy? \_\_\_\_\_

What percentage of bills will your policy cover? \_\_\_\_\_

If your insurance doesn't cover a percentage you may have a co-payment.

If so, what is your co-payment? \_\_\_\_\_

What is your insurance deductible? \_\_\_\_\_

Is your deductible effective per calendar year? \_\_\_\_\_

If not, when is your deductible effective? \_\_\_\_\_

How much of your deductible has been paid this year? \_\_\_\_\_

Is there a limit to the number a visits allowed? \_\_\_\_\_ If so what? \_\_\_\_\_

\_\_\_\_\_

Is pre-authorization required? \_\_\_\_\_ If so, when? Who must obtain it? And how can it be obtained? \_\_\_\_\_

\_\_\_\_\_

Is there a penalty for a pre-existing condition? \_\_\_\_\_

If so what? \_\_\_\_\_

Does your policy cover the following therapies done by the chiropractor in conjunction with a chiropractic treatment?

Such as muscle or ultrasound therapy, myofascial release or electrical stimulation: \_\_\_\_\_

Address of claims office: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature