

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