



Prime Health

Family & Sports Chiropractic Wellness Center



Insurance Information & Verification

Date _____

Insured _____ Phone _____

Insured's Address _____

Patient Phone _____ Patient's Address _____

Birth Date _____ Sex Male Female

Primary Insurance Company _____ Phone _____

Address _____ ID# _____

Secondary Insurance Company _____ Phone _____

Address _____ ID# _____

Relationship of Patient to Insured Same Person Spouse Child Other

Where are claims to be submitted if other than insurance company? _____

Illness/Injury/Accident Date _____ Time _____ AM PM Social Security # _____ Policy # _____

Group # _____ Insured's Employer _____ Phone _____

Address _____

Who verified coverage? _____ Title _____

Was this verification tape recorded? Yes No

Group Insurance

Is there coverage for Chiropractic care? Yes No

Amount of Deductible

_____ \$ /Individual _____ \$ /Family

Has deductible been met? Yes No

Coverage after deductible: _____ / _____ %

When is next deductible due? _____

Is there a maximum yearly benefit? _____

Is there a maximum visit limit? _____

X-ray coverage \$ _____ Maximum ceiling \$ _____

Are diagnostics applied to deductible? Yes No

Does the policy cover:

Exams Spinal Manipulations Physical Medicine & Rehabilitative

Procedures Orthopedic Supports Derma-therma-graphs

Nutritional Supplements Cervical pillows/collars, lumbar supports,

lumbo-sacral belt, etc. Intersegmental traction Other

Are special forms required? Yes No

Does your company honor or assign benefits to the doctor? Yes No

Is there an accident rider? Yes No

Personal Injury

Has injury been reported to insurance company? Yes No

Is there a deductible? Yes No If yes, how much? \$ _____

Worker's Compensation

Employer Name _____

Employer Phone _____

Employer Address _____

Has the injury been reported? Yes No

If yes, to whom? _____

Is patient employed with you now? Yes No

Do you have a company doctor? Yes No

Who authorized care? _____

Title _____

Employer Title/Job Classification _____

Auto Accident

Claim # _____

Has accident been reported to insurance company? Yes No

Is auto insurance: Primary Secondary

(If secondary, see Group Insurance Information at left)

Was patient hospitalized? Yes No X-rays taken? Yes No

Was a police report made? Yes No Ticket issued? Yes No

Agent Name _____

Address _____

Phone _____

Is there a deductible? Yes No If yes, how much? _____

Has an application for benefits been filed? Yes No