Health Insurance Verification Form

PRACTICE MEMBER NAME (PLEASE PRINT) _____

You must call to verify your health insurance benefits. The benefits quoted to you by your insurance company are not a guarantee of payment. We do not directly bill insurance for services provided at our clinic. Payment is expected at the time of service. We will, however, provide you with a receipt/superbill that includes diagnosis codes to assist you with possible insurance reimbursement.

It is important that you understand that health and accident insurance policies are an agreement between **you and your insurance company.** You are ultimately **responsible** for payment of your account should your insurance company fail to pay.

Dr. Loriann Laugle is currently an out-of-network provider. She has decided to **invest more time, money and energy in direct patient care.** Most insurance companies cover only spinal manipulation and select adjunct therapies for acute or medically necessary cases. While that's a very valuable service to provide, Dr. Loriann's specialty is **whole being wellness**, which is not covered by insurance. If your condition qualifies and based on your insurance policy, you may be eligible for out-of-network reimbursement.)

The following outline will help you to verify the **OUT-OF-NETWORK CHIROPRACTIC COVERAGE** in your policy. **Please contact your insurance company to complete the following questions and return this to the front desk at your next office visit. If this is an injury due to an accident, be sure to inform your insurance company.** Our team is ready to help if you have any questions or problems.

Is this accident related?	YES _____	NO _____	If yes, DATE: _____
Is your case Personal Injury?	YES _____	NO _____	
Is your case Worker's Compensation?	YES _____	NO _____	
Is your case Major Medical?	YES _____	NO _____	

OUT OF NETWORK CHIROPRACTIC BENEFITS

DATE you called your insurance company: _____

NAME of person who gave you the information: _____

CALL and ask the following questions:

1. Does my policy cover **OUT-OF-NETWORK CHIROPRACTIC**? YES _____ NO _____

If NO, you do not have to continue with the rest of the questions. You will not need to file insurance. Sign and date this form and return it to the front desk.

2. If **YES**, are there any **LIMITS** to my coverage? YES _____ NO _____
3. If **YES, WHAT ARE THEY**? (be specific) _____
4. Does chiropractic treatment by an out-of-network provider require pre-certification? _____
5. Is there a limit to the **NUMBER** of visits allowable? _____
6. What is the **DEDUCTIBLE**? _____
7. When does the deductible **START OVER**? _____
8. Has the deductible been paid? YES _____ NO _____ How much has been paid? _____
9. What **PERCENTAGE** of my bills will my policy cover? _____
10. What **PERCENTAGE** of **massage therapy (CPT CODE 97124)** will my policy cover? _____
11. What **PERCENTAGE** of **EMS therapy (CPT CODE 97014)** will my policy cover? _____
12. What **PERCENTAGE** of **therapeutic exercise (CPT CODE 97110)** will my policy cover? _____
13. What is the **EFFECTIVE DATE** of my policy? _____
14. Can **BENEFITS BE ASSIGNED** to the insurance subscriber? YES _____ NO _____
15. What is the **ADDRESS** where the claims should be sent?

NAME:
STREET:
CITY STATE ZIP:

16. To whose **ATTENTION** should it be addressed? _____
17. **INSURANCE CO. NAME**: _____
18. **INSURANCE CO. PHONE NUMBER:** _____
19. **POLICY TYPE:** GROUP INDIVIDUAL
20. POLICY #: _____ GROUP #: _____
21. **NAME** of Policyholder**:** _____

I hereby certify that I have contacted my insurance company and have verified my Medical Coverage.
Date:_____Patient Signature _____