CHIROPRACTIC INSURANCE VERIFICATION

Patient Name:	DOB:
Insurer:	Policy / Plan/ Group #
Insurance Phone#	
Verified By: Name/Employee ID#	Plan effective date:
	Billing Address
Call ID#	
Date of Verification:	

POLICY BENEFITS:

Time limit for filing:

Services provided by a DC covered: Yes No	In Network Out of Network
Doctor listed as a Network provider? Yes No	
If Out of Network are services provided by DC covered?	Yes No
If Out of Network benefits available does the plan send payments to patient or honor assignment?	Yes No

Is this a Marketplace (Exchange) plan? Yes No If yes type of metal Bronze Silver Gold Platinum Catastrophic
Pre existing waiting period? Yes No Effective date-
Does policy have a premium grace period? Yes No
Is there an active termination notice on file? Yes No
Deductible Amount: $ / How much has been met: $
Deductible Period:

Does the plan require Pre-Certification or Pre-Authorization for any service? Yes No If yes what services and any time frame or number of visits-
Chiropractic Treatment Limits: # of visits, $ cap, # days, diagnosis etc. Does the plan pay for PMR services per PPACA Rule 2706 (equality provision)? Weight loss? PPACA 2706 & 2707

Specific Covered Services	**Co-Pay**	**Co-Insurance**	**NC or Limit**
E&M Services 99201-99205 99211-99215			
X-Ray			
Chiropractic manipulation 98940-98942 98943			
Therapeutic exercise 97110			
Therapeutic activities 97530			
Massage 97124			
Manual therapy 97140			
Electrical stimulation 97014 or G0283			
Mechanical traction 97012			
Are PMR services payable when rendered by staff or LMT under DC direct supervision? Yes No			

NC = No Coverage Limit = max visits allowed

H.J. ROSS COMPANY