Patient's Guide to Insurance Verification

We encourage you to verify your insurance benefits and have developed the following guide to assist with the process. Please obtain all relevant information for your records.

You will find a customer service number on your insurance card. Please contact a service representative and ask the following questions about each recommended service.

It is always advised that you record the name of the person with whom you discussed your coverage.

Name:_____ Date:_____

Please ask the following questions.

Are the recommended treatments covered?..... ☐ Yes ☐ No

Do I need a primary care physician referral?..... ☐ Yes ☐ No

Is physical therapy covered when provided by a chiropractor? ……. ☐ Yes ☐ No

Do services need to be pre-authorized? ☐ Yes ☐ No

Is there a deductible? ☐ Yes ☐ No……Amount: _____

Has it been met this year? ☐ Yes ☐ No... ……Amount: _____

How many treatments may I receive? _____

Is there a maximum allowable payment for each service? ☐ Yes ☐ No…….Amount:_____

Is there a yearly maximum dollar amount allowable for therapy benefits?

☐ Yes ☐ No ……Amount:_____

We may perform one or more of the following Physical Medicine treatments:

Procedure	**Procedure**	**Code**
Physical Therapy Eval. / Re-eval	97001/ 97002	☐ Yes ☐ No
Manipulation	98940 – 43	☐ Yes ☐ No
Manual Therapy	97140	☐ Yes ☐ No
Exercises and stretches	97110	☐ Yes ☐ No
Neuro-muscular re-education	97112	☐ Yes ☐ No
Acupuncture	97780	☐ Yes ☐ No

Although our office has inquired about your insurance benefits for physical medicine/physical therapy please understand that your insurance carrier has advised us that ***payment of benefits will not be determined until your claim is received and reviewed according to the specifics of your plan.***
As the insured, it is your responsibility to know and understand the benefits of your health insurance plan, including any referrals that may be required. In order to assist you with this we have provided a patient guide to insurance verification.

I understand that if I agree to acupuncture treatments as part of my recommended therapy and, that this is a non-covered benefit under my insurance plan, I will be responsible for payment of this service at the time it is performed.

_____ **(please initial)**

Your signature is required, acknowledging that you understand and accept responsibility for the services we will be providing.

_____ _____

Signature of patient (responsible party) Date