

VERIFICATION OF BENEFITS

PATIENT NAME _____ INSURED NAME _____
PATIENT SS# _____ INSURED ID NO _____

INSURANCE COMPANY _____ Employer: _____
PHONE NO _____ Pol/Group#: _____
EFFECTIVE DATE _____ SPOKE TO _____ TIME _____

IS THIS AN EMPLOYER SELF FUNDED PLAN? YES / NO

HMO? Y / N If Yes are we In Network? Y / N If No, does the HMO plan have Out of Network Benefits? Y / N

Are We Participating Providers with this plan? Y / N Copy of Reimbursement Policy on File? Y / N

DEDUCTIBLE: IND _____ FAMILY _____ CAL YR / PLAN YR START DATE _____

REIMBURSEMENT % _____ PT RESP% _____ MAX OUT OF POCKET \$ _____

CoPay Amount: \$ _____ Apply by Service Type? _____ What Service Types: E/M Manip PT Rehab

MAX BENEFITS PER YR \$ _____ LIFETIME MAX \$ _____ FOURTH QUARTER CARRY OVER? YES / NO

COVERAGE FOR:

EVALUATION/MANAGEMENT CODES (992XX) YES / NO LIMITS: _____

WHERE XX= 01-05 FOR NEW PAT, XX=12-15 FOR ESTABLISHED PATIENT AND XX=41-45 FOR OP CONSULT.

SPINAL MANIPULATION CODES 98940,1,2 LIMITS _____

TREATMENT PLAN (PRECERT) REQUIRED YES / NO AFTER HOW MANY VISITS _____

ANY EXCLUSIONS ON PLAN _____

ANY DIAGNOSIS RESTRICTIONS _____

OUT PATIENT PHYSICAL MEDICINE MODALITIES AND PROCEDURES (97XXX) YES / NO

LIMITS: _____

Physical Therapy FOR DC? YES / NO

PRECERT REQUIRED FOR THERAPY? YES / NO

ANY EXCLUSIONS ON PLAN _____

ANY DIAGNOSIS RESTRICTIONS _____

DIAGNOSTIC SERVICES:

ANY ADDITIONAL DEDUCIBLE? YES / NO HOW MUCH \$ _____

X-RAY ? YES / NO LIMITS ON NUMBER OF VIEWS? _____

PPT TESTING? (97750) YES / NO

RANGE OF MOTION? (95851) YES / NO

INITIAL AND DATE _____