MICHIANA WELLNESS & LONGEVITY CLINIC
HEALTH INSURANCE VERIFICATION FORM

This questionnaire has been prepared as a help to you in obtaining all the benefits you are entitled to under the terms of your insurance policy. Please phone your agent, your insurance company, or talk with the person who handles your employer sponsored group insurance to obtain the following information. With this information in hand, you will be in a much better position to successfully manage the financial commitment involved with your treatment. **PLEASE RETURN THIS FORM TO THE CLINIC PRIOR TO YOUR INITIAL VISIT**

Date _____/_____/_____

Patient's Name _____
First Middle Last
Insured's Name_____
First Middle Last
Insured's Relationship to Patient: Self Child Spouse Parent Other (Employee, etc.)
Insured's: Phone (__) ___-_____ Insured's Date of Birth _____
Address (If different) _____
Policy No._____ Claim or ID No. (If Applicable)_____
Name of Insurance Co._____Phone No._____
Address to send Claim Forms_____
_____
***DATE** you called insurance company_____
***FULL NAME** of person who gave you the information_____

PLEASE ASK THE FOLLOWING QUESTIONS:

1. Does my policy cover Chiropractic care? ( ) Yes ( ) No
2. If Yes, Does my Chiropractor have to be a member of a Provider Network? ( )Yes ( ) No
3. If Yes, IDENTIFY TO THE PERSON THAT YOU ARE SPEAKING WITH THAT YOU WILL BE SEEING A **"NON-PARTICIPATING PROVIDER"**, AND HAVE THEM **ANSWER THE FOLLOWING QUESTIONS:**

1. Are there any limits to the number of visits my policy covers? ( ) Yes ( ) No
2. If Yes, then what are the limits?_____
3. What is the allowable dollar amount per visit?_____
4. What percentage of each visit will my policy cover?_____
5. Do I have a deductible? ( ) Yes ( ) No
6. If yes, how much is the deductible per year per individual on my policy?_____
7. Does my policy cover the following:

Adjunctive Physio-therapies ( )Yes ( ) No
ie., Traction, Trigger Point Therapy, Electrical or Muscle Stimulation, etc.
Therapeutic Massage ( ) Yes ( ) No
Exercise Consultations ( ) Yes ( ) No
Activities of Daily Living, Nutritional or Lifestyle Consultations ( ) Yes ( ) No
Examinations and/or Re-exams ( ) Yes ( ) No
X-Rays of spine or other regions? ( ) Yes ( ) No, covered at what % (80%, 100% or _____%)
Any Limits on Views or numbers of views? What are they?_____
Lab Work requested by a Doctor of Chiropractic ( ) Yes ( ) No (% Paid on Lab _____%)
ELISA, ALCAT or RAST Allergy Tests? ( ) Yes ( ) No
Candida Antibody Test? ( )Yes ( ) No
Hormone testing? ( )Yes ( ) No

(OVER)

INSURANCE VERIFICATION FORM (Continued)

Orthopedic supports (Braces) ( )Yes ( ) No
Custom-Made Orthotics? ( )Yes ( ) No
Nutritional Supplements (CPT A9150) ( ) Yes ( ) No
Diagnostic tests (e.g., EKG, Spirometry, Thermographic Mammograms, etc.)? _____
_____
Other Supplies or Educational Materials?_____

8. Do I need an MD's referral prior to receiving care? ( ) Yes ( ) No
9. Are there any RIDERS on my policy? ( ) Yes ( ) No
10. If Yes, then what are they?_____
11. What are the limits on my policy, if any?_____

Patient or Guardian Signature _____
Date Signed _____/_____/_____