

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare___Medicaid___Champus___CampVA___
Group Health Plan___ Other___Insured's ID Number_____
2. Patient Name:_____
3. Insured's Name (as it appears on the insurance card):_____
4. Patient's Address:_____
- City_____State_____ Zip_____ Tel #_____
5. Insured's Address (if same as patient put "same"):_____
- City_____State_____ Zip_____ Tel #_____
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):_____
- Other Insured's Policy or Group Number:_____
- Other Insured's Date of Birth:_____ Male_____ Female_____
- Employer's Name or School Name:_____
- Insurance Plan Name or Program Name:_____
8. Is the condition we are treating related to current or previous employment? Yes___ No___
9. Is the condition we are treating related to an auto accident? Yes___ No___
10. Is the condition we are treating related to another type of accident? Yes___ No___
11. Insured's Policy Group or FECA Number:_____
- Insured's Date of Birth:_____ Male_____ Female_____
- Employer Name or School Name:_____
- Insurance Plan Name or Program Name:_____
12. Is there another health benefit plan? Yes___ No___

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___ No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes___ No___
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___ Name of Company_____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___

Insurance Company _____ Phone # _____

Claims Address _____ Fax # _____

Name and title of person giving information: _____

HCFA 1500 form okay? Yes No

What is your deductible? \$ _____ Deductible remaining? \$ _____

Is deductible: annual or per incident? (circle one) Date deductible starts: _____

Percentage payment: _____ %

Is there a maximum number of visits allowed? Yes No If yes, number: _____

Will you pay for therapy? Yes No Maximum # per visit _____ per year? _____

Any \$ limitations on visits? _____ Therapy? _____

Will you accept E/M codes (99201-99204) from chiropractors? _____

Will you accept CMT (Chiropractic Manipulative codes 98940-98943)? _____

Any x-ray limitations? _____

Do you require pretreatment authorization? Yes No

Procedure: _____

Do you pay for examinations? Yes No

Any re-exam stipulations? _____

Do you pay for: Supports Pillows Vitamins/Supplements Orthotics

Any limitations? _____

Do you accept and honor assignment of benefits? Yes No

Add'l Notes: _____

Person taking information: _____ Date: _____