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:_____