

INSURANCE BENEFITS VERIFICATION

CHIROPRACTIC SOLUTIONS *by dr julie*

Tax ID: 20-4751168

Patient Name:		SS#:	
DOB:		Group #:	
Insurance Provider		ID #:	
Date Calling:		Number Dialed:	
Ins. Rep:		Direct Line or Extension	
Effective Date:		Deductible Amount:	
Coverage:	Chiro. Y <input type="checkbox"/> N <input type="checkbox"/> P.T. Y <input type="checkbox"/> N <input type="checkbox"/>	Deductible Paid to Date:	
Copay:		# Visits/Year:	Chiro:
			P.T.:
Max. Out of Pocket:	\$	Limitations:	
Exam:	99202-4 Y <input type="checkbox"/> N <input type="checkbox"/>	Therapeutic Exercise:	97110 Y <input type="checkbox"/> N <input type="checkbox"/>
X-Ray:	72010-72050 Y <input type="checkbox"/> N <input type="checkbox"/>	Therapeutic Activity:	97530 Y <input type="checkbox"/> N <input type="checkbox"/>
Adjustment:	98940-2 Y <input type="checkbox"/> N <input type="checkbox"/>	Neuromuscular Re-education	97112 Y <input type="checkbox"/> N <input type="checkbox"/>
Extremity Adjustment:	98943 Y <input type="checkbox"/> N <input type="checkbox"/>	E/S:	97014 Y <input type="checkbox"/> N <input type="checkbox"/>
U/S:	97035 Y <input type="checkbox"/> N <input type="checkbox"/>	ICE/HEAT:	97010 Y <input type="checkbox"/> N <input type="checkbox"/>
Notes Required:	Y <input type="checkbox"/> N <input type="checkbox"/>	Precert/Referral Med. Nec. Ltr.	Y <input type="checkbox"/> N <input type="checkbox"/>

DATE: _____

_____ CHIROPRACTIC SOLUTIONS REPRESENTATIVE:

DATE: _____

_____ PATIENT SIGNATURE:

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