PRIORITY LIFE
CHIROPRACTIC & MASSAGE

INSURANCE VERIFICATION FORM

Priority Life Chiropractic & Massage will gladly bill your insurance for your visit, however, it is the patient's responsibility to be aware of coverage and benefits. If you are a new patient or an existing patient and have new insurance, please call your insurance company to answer the questions below. Once you find out your benefits and eligibility for chiropractic and massage, please bring this completed form with you to your next appointment. If you do not bring this completed form with you to your appointment, you will be charged our Time of Service Fee for the exam and/or adjustment. Thank you for your cooperation.

Please be aware that this is a quote of benefits and not a guarantee of payment. If an insurance company provides you with inaccurate information, they may not honor the benefits that were quoted.

Patient Name:_____ Date of Birth:_____

Insurance ID#:_____ Group ID#:_____

Insurance Company:_____ Phone Number: _____

For Chiropractic Treatment

Do I have Chiropractic coverage? YES or NO What is the effective date of coverage? ____/____/____

- Do I have a copay? YES or NO
  If **yes**, how much is the copay per visit? $_____
- Do I have a Co- Insurance? YES or NO
  If **yes**, what is the coinsurance amount? _____%
- Are Chiropractic services subject to a deductible? YES or NO
  If yes, what is my deductible for the year? $_____ What is the amount remaining? $_____
- Are there a limited number of visits per year? YES or NO
  If yes, how many visits are allowed per year? _____ Number of visits remaining _____
- Is this a calendar year plan? YES or NO
  If no, what is the plan start and end date? _____ - _____
- Is my chiropractic benefit combined with any other alternative care services? YES or NO
  (If the answer is YES to the question above, you will be responsible for keeping track of visits at other facilities – we have no way of keeping track of services received elsewhere)
- Is there a maximum dollar amount allowed per year for Chiropractic treatment? YES or NO
  If yes, what is the maximum amount allowed per year? $_____ How much has been met so far, this year? $_____
- Is there a maximum dollar amount allowed per office visit? YES or NO
  If yes, what is the maximum amount allowed per visit? $_____
- Is Pre-Authorization required for this service? YES or NO
- If yes, where can pre-authorization be obtained?
  Company Name: _____ Phone number/website: _____
- Is a referral from a primary care physician/medical doctor required for this service? YES or NO

For Massage Therapy

- Will Massage Therapy be covered if performed by a Licensed Massage Therapist (LMT) using the code **97124**? YES or NO
- Do I have a copay? YES or NO If yes, how much is the copay? $_____
- Do I have a Co- Insurance? _____ YES or NO
  If yes, what is the percentage covered by the insurance company? _____ What is the percentage I (the patient) am responsible for? _____
- Is Massage Therapy subject to a deductible? YES or NO
  If yes, what is my deductible for the year? $_____ What is the amount remaining? $_____
- Are there a limited number of visits per year? YES or NO
  If yes, how many visits are allowed per year? _____ Number of visits remaining _____
- Is there a maximum dollar amount allowed per year for Massage Therapy? YES or NO
  If yes, what is the maximum amount allowed per year? $_____
- Is there a maximum amount allowed per office visit? YES or NO
  If yes, what is the maximum amount allowed per office visit? $_____
- Is Pre-Authorization required for this service? YES or NO If yes, where can pre-authorization be obtained? Company Name: _____ Phone number/website: _____
- Is a referral needed for this service? YES or NO
  If yes, can I get a referral from a Chiropractor or must the referral come from a Medical Doctor?
  _____
- Is my Massage Therapy benefit combined with any other alternative care services? YES or NO
  (If the answer is YES to the question above, you will be responsible for keeping track of visits at other facilities – we have no way of keeping track of services received elsewhere)

Other information:

- What address should claims be sent to?
  _____
- Name of the representative you spoke with: _____Date:_____
- Reference number (if applicable): _____ Date: _____

Please be aware that this is a quote and not a guarantee of payment. If an insurance company provides you with inaccurate information, they may not honor the benefits that were quoted.

Please be sure to bring this completed form to your next appointment. If you have any questions or concerns, please let us know!

Thank you – The Team at Priority Life Chiropractic and Massage