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 her/his coverage and co-pay, as well as any deductible, insurance limitations, etc.

Please complete and bring this form with you to your first appointment. If you are an existing patient and have new insurance, please bring this completed form with you to your next appointment. If you do not bring this form filled out with you to your appointment, you will be charged our Time of Service Fee for the exam and 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#:_____

Relationship to Insured: _____ Employer:_____

Insurance Company:_____ Phone Number: _____

Please call your insurance company to ask and answer the questions below to find out about your benefits and eligibility for chiropractic and massage. You can call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

Do I have Chiropractic coverage? YES or NO

- How many visits are allowed per year? _____ Number of visits remaining _____
- Is this a calendar year plan? YES or NO (circle one) If no, what are the dates the plan starts and ends? _____ - _____
- What is the beginning date of coverage? _____ (mm/dd/yyyy)
- 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 amount allowed per year for Chiropractic treatment? YES or NO
  If yes, what is the maximum amount allowed per year? $_____
- What is the maximum 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, who is responsible for obtaining the pre-authorization? Name: _____ Phone number/website: _____
- Is a referral required for this service? YES or NO
- What is my deductible for the year? $_____ What is the amount remaining? _____
- Are Chiropractic services subject to this deductible? 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? _____%

- The name of the representative you spoke with: _____ Reference number (if applicable): _____ Date: _____
- What is the address for claims submission? _____
- Payer ID#_____

For Massage Therapy

- Is Massage therapy covered by a Licensed Massage Therapist (LMT) using the code **97214**? YES or NO
- How many visits are allowed per year? _____ Number of visits remaining _____
- What is the maximum 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? $_____
- What is the beginning date of coverage? _____
- Is Pre-Authorization required for this service? YES or NO If yes, who is responsible for obtaining the pre-authorization? 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 there a maximum amount allowed per office visit? YES or NO If yes, what is the amount? $_____
- Is there a maximum amount allowed per year? YES or NO If yes, what is the amount? $_____
- 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? _____
- Does the deductible apply to massage? YES or NO
- Who should claims be sent to? _____

  What is the address to mail claims to?

  _____
- Payer ID#_____
- 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.

If you have any questions or concerns regarding the information you received from your insurance company, please let us know! We will be happy to discuss this information with you.