Patient Insurance Benefits Verification Questionnaire

INSTRUCTIONS

1. Print and complete the form below OR be sure to obtain all the required information regarding your personal policy benefits and be prepared to complete this questionnaire at RST.

2. Carefully read the questionnaire and call the number on the back of your insurance card to complete the questionnaire.

3. Failure to provide accurate information may result in inaccurate estimates collected at the time of service and will require additional financial responsibility on your behalf.

RST & Montgomery Chiropractic

Patient Insurance Benefits Verification Questionnaire

MEMBER ID#: GROUP #: Primary/Secondary (circle one)

When calling your insurance, please address yourself as a patient of **"RST & Montgomery Chiropractic"** and ask the following questions, as written:

Chiropractic Treatment

1)Does my Insurance have a DEDUCTIBLE for *Chiropractic* Treatment? $ _____

   b. What is the calendar year for this? Jan-Dec / July-June / Other:
   c. If some of the DEDUCTIBLE has been met, what is amount is remaining? $ _____

2) How many Visits per year does my Insurance pay? _____ **Is Authorization Required?**
   a. What is the calendar year for reset of visits per year? Jan-Dec / July-June / Other:
3) Do I have a Copayment per visit? $_____or a percentage split _____%

Physical Therapy Performed by a Chiropractor

1) Do I have a "separate" DEDUCTIBLE for Physical Therapy performed by a Chiropractor? ***Yes / No***
   a. If ***Yes***, what is the amount $_____ / remaining? $ _____
   b. What is the calendar year for this? Jan-Dec / July-June / Other:
2) How many "separate" Physical Therapy **visits** performed by a Chiropractor do I have? _____
   a. What is the calendar year for this? Jan-Dec / July-June / Other:
3) Do I have a "separate" Copayment per visit? $_____or a percentage split _____%
4) (If UHC/OPTUM Insurance) Do I need a referral form my primary care provider? ***Yes / No***

Representative Name: _____

Call Reference Number #_____

Physical Therapy CODES THAT MIGHT BE BILLED by RST & Montgomery Chiropractic:	
97014	Electrical Stimulation
97140	Myofascial Manual Therapy
97110	Therapeutic Exercise
97012	Mechanical Traction

I acknowledge that I have contacted my Insurance Company and have received answers to the above questions by speaking with the insurance representative named above.

X _____ / / _____

Patient Signature **Date**

◯ (check circle if applicable) I acknowledge that I DID NOT contact my Insurance Company regarding the above questions and agree to be responsible for any portion of charges that my Insurance Company does not pay.

X _____ / / _____

Patient Signature **Date**