Movement Rx PAIN relief

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MovementRxTeam.com

Insurance Verification Form

We encourage all patients to verify their insurance benefits prior to their first visit to fully understand your policy and treatment coverage. Please call the customer service number on the back of your insurance card.

Name: _____ DOB: ____/___/_____

Policy Holder's Name: ___ _____ DOB: ____/___/_____

Primary Insurance: _____ ID#: _____

Please ask the following questions:

Effective date of the policy: ____/___/_____

Is my provider covered/part of my network? [ ] Yes [ ] No-Ask next question.

Is there an out of network benefit? [ ] Yes [ ] No

Details: _____

Is there a deductible for my policy? [ ] Yes-Ask next question [ ] No

Amount of deductible: _____ Amount of deductible met: _____

Is the deductible based on a fiscal or a calendar year? [ ] Fiscal [ ] Calendar

If based on a fiscal year: _____ to _____

Does the deductible apply to chiropractic benefits? [ ] Yes [ ] No

How many chiropractic treatments may I receive? _____ How many have been used? _____

How many adjunctive therapy treatments may I receive? _____ How many have been used? _____

What is my co-payment amount? _____ What is my co-insurance amount? _____

Are these commonly recommended treatments covered with my plan?

Procedure	**Procedure Code**		
New Patient Examination	99201-99203	[ ] Yes	[ ] No
Established Patient Examination	99211-99213	[ ] Yes	[ ] No
Spinal Manipulation	98940-98941	[ ] Yes	[ ] No
Extremity Manipulation	98943	[ ] Yes	[ ] No
Therapeutic Exercise	97110	[ ] Yes	[ ] No
Manual Therapy	97140	[ ] Yes	[ ] No

Is durable medical equipment covered (L3000)? [ ] Yes [ ] No Details: _____

Is advanced imaging covered (MRI)? [ ] Yes [ ] No Details: _____

Is pre-certification required for advanced imaging? [ ] Yes [ ] No

Pre-certification point of contact: Phone: _____

Is pre-certification needed for any other treatment procedures? [ ] Yes [ ] No On what services: _____

Pre-certification point of contact: Phone: _____

Reference # for your call:_____ Date of call: ____/___/_____

Please fax or bring completed form with you for your first scheduled appointment.