41 Princess Street, Leamington, ON
519.322.4859 • www.buzekchiropractic.ca

Insurance Verification Form

This form is intended to assist in facilitating your health benefit claims. Please call your extended health insurance customer service line and gather the following information so you can understand your coverage and be better able to determine if any co-payments are required for the services received in our office.

Date: ____________________

Name: ____ Patient Number: ________________

Primary Insurance Company Name:____

Plan/Policy/Group #: ____ Id #: _________________________________

Name of Insured Member: ____ Date of Birth: __________________________
Relationship to Patient: ☐ Insured Member ☐ Spouse ☐ Child ☐ Other: _____________________________________
Effective Date: ____
Plan Benefit Year: (ie. The date your coverage renews- Day One, Calendar, Feb-Mar etc.)__________________
Does Plan Allow For Assignment of Benefits? ☐ Yes ☐ No

CHIROPRACTIC COVERAGE:

Maximum Coverage Per Benefit Year: $______________ Amount Covered Per Visit: $________/________%
Is there a deductable? ☐ No ☐ Yes $_________________
Is this coverage maximum combined with other health services? ☐ Yes ☐ No
Is a prescription required for chiropractic services? ☐ Yes ☐ No

REGISTERED MASSAGE THERAPY:

Maximum Coverage Per Benefit Year: $______________ Amount Covered Per Visit: $________/________%
Is there a deductable? ☐ No ☐ Yes $_________________
Is this coverage maximum combined with other health services? ☐ Yes ☐ No
Is a prescription required for massage services? ☐ Yes ☐ No

CUSTOM MADE ORTHOTICS COVERAGE:

Maximum Coverage Per Benefit Year: $______________ Amount Covered Per Pair: $________/________%
Is there a deductable? ☐ No ☐ Yes $_________________
How often is patient eligible for orthotics? __________________ Is patient currently eligible? ☐ Yes ☐ No
Is a prescription required from Medical Doctor? ☐ Yes ☐ No
Can a chiropractor dispense custom made orthotics under this plan? ☐ Yes ☐ No