Northwest Family
CHIROPRACTIC & MASSAGE

# Insurance Verification Form

This form is intended to help a practice member when verifying their insurance benefits. Please call your insurance customer service line and gather the following information so you can understand how your policy works.

Please provide this information to our front desk staff:

Insurance Company Name:_____
Is this company your (1) Primary or (2) Secondary Insurance

Patient Name: _____ Effective Date:_____
Insurer: _____ Insurer Date of Birth: _____

Spinal Manipulation: # per year _____
Plan Deductible: _____
(Does the deductible apply to the spinal manipulation visits? YES / NO)
Co-Pay per visit: $_____
Co-Insurance: $_____

Some plans pull services from other parts of your policy. Please understand if your policy processes these services differently from your spinal manipulation.

X-ray Benefit: _____
Examination Benefit: _____
Physical Medicine Benefit: _____

Name of Customer Service Representative:_____
Name of practice member who verified this information: _____
Date of Verification: _____