

Optimal Care
14207 Park Center Dr.
Suite 106
Laurel MD 20707
Phone (301)-362-5868 Fax (301)-362-5869

Insurance Verification Form

We encourage all patients to verify their insurance benefits prior to their first visit to fully understand their 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#: _____

Secondary Insurance (For Medicare patients only): _____ ID#: _____

Please ask the following questions:

Effective date of the policy: ____/____/____

Is my provider covered/part of my network? Yes No – Ask the 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? _____ Or what is my co-insurance amount? _____

Are these commonly recommended treatments covered with my plan?

Procedure	Procedure Code	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New Patient Examination	99201-99203	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Established Patient Examination	99211-99213	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spinal Manipulation	98940-98941	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Extremity Manipulation	98943	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle Stimulation	97014/G0283	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Therapeutic Exercise	97110	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Manual Therapy	97140	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Massage	97124	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Activities of Daily Living	97535	<input type="checkbox"/> Yes	<input type="checkbox"/> No
X-Ray Analysis	72010	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is durable medical equipment covered (L3020)? Yes No Details: _____

Is pre-certification needed for any other treatment procedures? Yes No

Pre-certification point of contact: Phone: _____ On what services: _____

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

Please fax to us OR bring the completed form with you on your first scheduled appointment.