Insurance Verification Form

Dr. Michael T Martin
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Clear Lake Chiropractic
907 El Dorado Blvd Ste B
Houston, TX 77062

Phone 281-488-2291
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Patient: ____ Patientǫs Date of Birth: _________________________

Patientǫs SS# ______________________________Member Number ____

Insured Name: ___________________________________ Insuredǫs Date of Birth: ____________________________

Insuredǫs SS #: ___________________________________Unique ID #: ______________________________________

Patientǫs Zip Code ____________Relationship:_____Self _____Spouse ____Child _____Other (Specify) _____________

Date of Injury/Onset:____________________Chief Complaint: ____

Insurance Company:____ Plan: ________________________________

Insurance Company Phone Number:____

Claim/GroupNumber:____

Network ______________ In_____ Out ______Employer ____

Effective Date:_______________________________Termination Date:_______________________________________

Individual Deductible:_______________ Family Deductible __________________ Amt Met: Individual _______________

Amt Met: Family _____________Out of Pocket Amount:____________Amt Met: Ind: ___________Family___________

Copay: __________________ Co-Insurance Amount______________________ Carry Over ______________________

Benefit Year:______________LifeTime Max:______________ PCP : ____

X-Rays __________________ Diagnostic/Lab Testing _____________________ Pre-Existing ____________________

Chiropractic Covered: _______ Yes _______ No Referral Required: _______ Yes _______ No _____Verbal _____ Written

Dollar Limit per year:_______________Dollar limit per visit:_____________Procedures per visit: ____________________

Manipulations:_____________________Office visit:_____________________Modalities:___________________________

Number of visits:_________________ Visits used:____________________ Physical Therapy:______________________

Claims Address:____

City,St.Zip: ____

Electronic Payor Number:____

PreCert Phone#: _____________________________________ Fax #: ____

Additional Comments:

Insurance Representative_______:_________________________________Ref # ____________________________

PM Staff member: ____Date __________________

A quote of benefits is not a guarantee of payment. Benefits are determined when the claim is processed at the carrier. I understand it is my responsibility to know what my policy covers. If the insurance determines my benefits are different from this quote, the insurance determination will apply and my responsibility will be based on the insurance determination

Patient Signature ____ Date ______________________________

Practical Management
4910 Comal River Loop
Spring, TX 77386

Phone 281-350-2330
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