

PORTER & CLARK CHIROPRACTIC

29100 Gateway Blvd., Ste 100, Flat Rock, MI 48134 Phone: 734-379-9200 Fax 734-379-9229

INSURANCE VERIFICATION

It is your responsibility to verify your own insurance coverage for chiropractic care. Until you provide us with the following information, you may be charged full price for all services you receive from Porter & Clark Chiropractic.

BCN/Blue Care Network policy holders—

A referral from your Primary Care Physician is needed in order to have chiropractic visits billed to your insurance company. Please ask for a Global referral for an Initial Office Visit (billing code 99203). Our NPI # is 1316009756

Date I called insurance company: _____

I spoke to: _____ Is there a Reference #? _____

How does my Policy year run? (I.e. Jan-Dec? July-June?): _____

Deductible? Does my policy have one? YES or NO How much is it? _____ Met? _____

Is there a maximum amount that my insurance will contribute to chiropractic care? YES or NO

If so, how much? _____

Office visit/exams (Exams – code 99203)

Does insurance cover Office visit-exams? YES or NO How often? _____

Does my deductible apply to exams? YES or NO What is my copay/coinsurance? _____

Office visit/re-exams (Re-exams – code 99213)

Does insurance cover Office Visits—re-exams? YES or NO How often? _____ How long after initial exam? _____

Does my deductible apply to exams? YES or NO What is my copay/coinsurance? _____

Adjustments (Manipulation – code 98941)

Does insurance cover Spinal Manipulations? YES or NO

Does my deductible apply to exams? YES or NO What is my copay/coinsurance? _____

Is there a visit limit? _____ Have I used visits at another Chiropractor? YES or NO If so, how many? _____

I understand that this information which was provided by my insurance company may or may not be accurate, is **NOT** a guarantee of payment, and may change at **ANY TIME**.

I agree to be responsible for payment of all services rendered (on my or my dependents behalf) **DENIED or NOT** covered by my insurance company.

Patient Name: _____

Patient Signature: _____ Date: _____