HEALTH INSURANCE VERIFICATION – SCHILLINGER CHIROPRACTIC GROUP, INC.

The purpose of this form is to enable you to determine whether or not you have insurance that will cover chiropractic in our office. We ask that you complete this form so that you have a clear understanding of the insurance coverage that is available to you. Since you are the insured with your insurance carrier and have a contract with them, they should provide you with the following information. This is also an opportunity for you to clarify any questions you might have for them regarding your coverage.

While Dr. Schillinger's office will do their best to communicate with your carrier, it's unlikely they'll give us all of the information we need because we are not insured with them like you are.
PLEASE COMPLETE THIS SECTION:

Patient's Name: _____ Patient's Date of Birth: _____

Insured's Name: _____ Insured's Date of Birth: _____

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's ID Number: _____ Group/Policy/Plan/Control Number: _____

Insurance Carrier's Name: _____

PLEASE CALL your carrier directly and ask them the following questions. They will need the following information: EIN: 74-3094885; NPI: 1093743460

Is Dr. Mark Schillinger, DC, an in-network or out-of-network provider? ☐ In ☐ Out
Am I eligible under this health plan for chiropractic care in this office? ☐ Yes ☐ No
(**If the answer is No, STOP HERE and skip to the section below** *)
What is the effective date of coverage? _____
Is a Primary Care Physician (PCP) referral required? ☐ Yes ☐ No
Is there a co-payment or co-insurance per visit? ☐ Yes ☐ No If yes, what is it? _____
Is there a maximum dollar amount allowed per visit? ☐ Yes ☐ No If yes, what is it? _____
Is there a maximum number of visits allowed per year? ☐ Yes ☐ No If yes, what is it? _____
How much is my individual deductible? $_____ Has it been met this year? ☐ Yes ☐ No
If it has not been met, how much has been met? $_____
When does the deductible begin? ☐ Calendar year ☐ Other If other, please explain_____
Are Evaluation and Management services covered? ☐ Yes ☐ No. If yes, what %/$: _____
Are supports/appliances covered (Durable Medical Equipment)? ☐ Yes ☐ No
Since Dr. Mark may submit claims electronically for me, what is the Payer ID # _____

If Dr. Schillinger's office has to send the claim by mail, where are claims to be mailed for processing?

Name_____

Address: _____City: _____State: _____

Zip Code: _____ Toll Free Telephone Number:(_____) _____

* Name of the person who provided you with this information: _____

* Tracking Number, Reference Number or Log Number: _____

* Was a waiver or disclaimer provided? ☐ Yes ☐ No If yes ☐ Recording ☐ Verbally by representative.

* Their phone number: (_____) _____ Date information was obtained: _____

Your Signature: _____ Date completed: _____