**Van Every Family Chiropractic Center**
**4203 Rochester Rd., Royal Oak, MI 48073 phone 248-616-0900 fax 248-616-1911**

# 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 Van Every Family Chiropractic Center.

**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 1609872084.

Date I called insurance company: ____________
I Spoke to: ___________________ Is there a Reference #? : _________________
How does my Policy year run? (ie Jan-Dec? July-June?): _______________________

**Deductible**? Does my policy have one? YES or NO How much is it? ____ How much has already been met? ____
Is there a maximum amount that my insurance will contribute to chiropractic care? YES or NO How much? _____

**Office visit/exams** (Exams - code 99203)
Does insurance cover Office Visits—exams? YES or NO How often? ____________
How much do I pay if my deductible is NOT met? ______ What is my Copay after my deductible is met? _______

**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? ___________
How much do I pay if my deductible is NOT met? ______ What is my Copay after my deductible is met? _______

**Adjustments** (Manipulation - code 98941)
How many Manipulations (adjustments) does insurance contribute to? ___________________
Have I used visits at another chiropractor? YES or NO If so, how many were used? ___________
How much do I pay if my deductible is NOT met? ______ What is my Copay after my deductible is met? _______

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__________________________