HATBORO FAMILY WELLNESS INSURANCE INFORMATION

Insurance is a contract between the insured (patient) and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover chiropractic services. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer.

If you have determined that your insurance will cover your care in our office, we will supply you with all of the paperwork necessary for you to get reimbursed quickly. We will **give you a statement** at the end of your first week and then once a month after that. When you send in your statements, your insurance company will **reimburse you directly**. **The insurance company is responsible to you, as the subscriber, not to us, the provider.** Utilize the Insurance Verification Form below when you inquire about your coverage.

INSURANCE VERIFICATION FORM

Patient's Name _____ Birth Date _____ Today's Date_____

Please have the following information when calling your insurance company:

1) Insurance company's phone number (on the back of your card):_____

2) Policy holders name (if different from patient):_____

Please obtain and verify the following information. Our office and the insurance company cannot process your claim without this information.

1. Name of the person giving you this information:_____

2. Ask if your policy has coverage for ***"out of network"*** providers? _____ If yes, continue. If no, then your care in our office is not reimbursable by your insurance company.

A. What is the yearly out of network deductible: Per Person: _____ Per Family: _____

B. How much of the out of network deductible has been met this year: _____

C. What is the co-pay or co-insurance: _____

D. Is there a limit to the number of visits? _____ Dollar limit?: _____

If yes, how many visits are allowed and/or what is the $ limit?: _____

E. Are services limited by "Medical Necessity"?_____

F. Do they cover Maintenance or Wellness **Chiropractic** Care?_____

G. What is the effective date of the policy: _____

H. Policy holder's name: _____and DOB_____

Group # (if applicable to your policy):_____

I. Name and address of the insurance office where the claims are sent:

_____

_____

_____

Thank you for obtaining and verifying this information with your insurance company. We expect they will reimburse you or your account as noted above.