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Insurance Benefit Form

Patient Name: _____ Insurance: _____

This form is designed to help you communicate with your insurance company.
To access your benefits, please ask the following question:

Does my policy cover Chiropractic? _____

What are the limits to my coverage? _____

What is the limit to the number of visits allowable? _____

Is there a deductible, if so how much? _____

Is that per calendar year? _____

Per person? _____

Has it been met? _____

If not, how much has been paid? _____

Will they cover custom fitted orthotics? _____

If so, what is the amount covered/number of pairs? _____

Doctor referral required? _____

How long does insurance keep prescription on File? _____

Will they cover custom orthopaedic shoes? _____

Will they cover compression stockings? _____

Will they cover bracing? _____

Coverage for Registered Massage Therapy? _____

What percentage of my bills will my policy cover? _____

Does the insurance company require a Paid Receipt? _____

Does my plan allow assignment of benefits to my provider? _____

Name & address of the insurance office where the claims are to be sent:

Policy/contract number: _____ Plan/member ID: _____