INSURANCE VERIFICATION FORM (in network)

Patient's Name: _____

Date of Birth:_____ 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. Your claim cannot be processed without this information. Thank you.

1. Ask for the name of the person giving you this information:_____
2. Ask if your insurance company is "***in network***" with Dr. Melissa Osborn or Lifetime Family Chiropractic.
3. Ask if you have chiropractic coverage for ***"in network"*** providers. If yes, please continue to verify type and amount of coverage.
   - A. What is the yearly deductible: Per Person: _____ Per Family: _____
   - B. Does the deductible apply to chiropractic (exam, x-rays, adjustments) :_____
   - C. How much of the deductible has been met this year: _____
   - D. What is the co-pay or co-insurance for the exam : _____
   - E. What is the co-pay or co-insurance for the x-rays : _____
   - F. What is the co-pay or co-insurance for the adjustments : _____
   - G. Is there a limit to the number of visits or $ amount? _____If yes, how many visits are allowed and/or what is the $ limit? _____
   - H. Are services limited by "Medical Necessity"? _____ _____
   - I. Do they cover Wellness or Maintenance Care? _____
   - J. What is the effective date of the policy: _____
   - K. Policy holder's employer: _____ID#_____
     Group # (if applicable to your policy):_____
   - **L. Name and address of the insurance office where the claims are sent:**

     _____

     _____

*****All Dr's (Including Dr. Navpreet Saini & Dr. Kyle Conn) bill under the Group: Dr. Melissa Osborn, PLLC*****

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

LIFETIME FAMILY CHIROPRACTIC 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.

PLEASE READ **ALL** THE FOLLOWING INFORMATION TO CLARIFY INSURANCE PROCEDURES.

Insurance companies, such as HMOs, PPOs 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. (See reverse for details)

If you have determined that your insurance will cover your care in our office, they will require direct billing from us. They are **responsible to you**, as the subscriber, not to us, the provider. You can utilize the "Insurance Verification Form" (on the back of this form) when you inquire about your coverage.

We will supply them with the necessary information to remit payment to our office on your behalf. Please understand that you are responsible to pay for all services not covered by your insurance company including deductibles, co-payments and any other balances not reimbursed by the insurer.

NOTE: You **must verify** the type and amount of coverage before we can submit claims on your behalf. On the reverse side of this form is an **"Insurance Verification Form"** that will assist you in obtaining all the vital information needed for us to accept and submit bills to your insurance. Until we receive this information, your account will be on a cash basis.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLETE ALL FORMS NECESSARY TO ALLOW LIFETIME FAMILY CHIROPRACTIC TO ASSIST ME WITH INSURANCE REIMBURSEMENT. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL SERVICES RECEIVED SHOULD MY INSURANCE FAIL TO REMIT PAYMENT.

Patient Name Printed: _____

Patient Signature: _____ **Date:** _____