



# CALIFORNIA NEUROHEALTH CHIROPRACTIC & ACUPUNCTURE INSURANCE POLICY

Our policy is set up to utilize direct payment from insurance companies. This is done as a service to our patients and there is no charge for this service. However, it is important that you understand that health and accident insurance policies are an arrangement between **you and your insurance company**. You are responsible for all service charges incurred in our office. We expect payment in full when the services are rendered **until** your insurance coverage has been verified.

Patient's Name \_\_\_\_\_

Please fill out this form and return it to our office at your next visit. HERE IS WHAT YOU DO TO VERIFY COVERAGE FOR CHIROPRACTIC AND ACUPUNCTURE CARE:

**DATE** you called your insurance company \_\_\_\_\_

**NAME** of person who gave you information \_\_\_\_\_

1. Call your insurance company and ask the following questions:

- a. Does my policy cover Chiropractic? \_\_\_\_ yes \_\_\_\_ no  
Does my policy cover Acupuncture? \_\_\_\_ yes \_\_\_\_ no  
If yes, are there limits to my Chiropractic coverage? \_\_\_\_ yes \_\_\_\_ no  
If yes, are there limits to my Acupuncture coverage? \_\_\_\_ yes \_\_\_\_ no

What are those limits to my Chiropractic coverage? (Be as specific as possible): \_\_\_\_\_  
\_\_\_\_\_

Is there a requirement for an M.D. referral? \_\_\_\_ yes \_\_\_\_ no

What are those limits to my Acupuncture coverage? (Be as specific as possible): \_\_\_\_\_  
\_\_\_\_\_

Is there a requirement for an M.D. referral? \_\_\_\_ yes \_\_\_\_ no

- b. What is the deductible? \_\_\_\_\_  
Has it been met? \_\_\_\_ yes \_\_\_\_ no      If no, how much has been met? \_\_\_\_\_  
Is there a carry-over? \_\_\_\_ yes \_\_\_\_ no      Is there a family deductible? \_\_\_\_ yes \_\_\_\_ no

- c. What percentage of my bills will my policy cover? \_\_\_\_\_  
OR is there a pre-set co-payment?      How much? \$ \_\_\_\_\_  
If there is a pre-set co-payment, does that include ALL services? \_\_\_\_ yes \_\_\_\_ no  
OR is there a separate co-payment for other services:  
Exam \$ \_\_\_\_\_  
X-ray \$ \_\_\_\_\_  
Physical Therapy \$ \_\_\_\_\_  
Manipulation \$ \_\_\_\_\_

Once the deductible is met do the visits then start counting? \_\_\_\_ yes \_\_\_\_ no

Percentage paid by insurance % \_\_\_\_\_ visit max \_\_\_\_\_ visits remaining \_\_\_\_\_ visit \$ max \_\_\_\_\_

97140 Manual Therapy \$ \_\_\_\_\_  
97112 Neuromuscular re-education \$ \_\_\_\_\_  
97110 Therapeutic exercises \$ \_\_\_\_\_

d. Does my policy cover cervical pillows? \_\_\_\_\_ yes \_\_\_\_\_ no  
Nutritional Supplements? \_\_\_\_\_ yes \_\_\_\_\_ no    Structural Supports? \_\_\_\_\_ yes \_\_\_\_\_ no

e. What is the effective date of my policy? \_\_\_\_\_

f. Can benefits be assigned to my Dr.'s office? \_\_\_\_\_

g. What is the address of the office where the Acupuncture claims are to be sent?

Name of company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

To whose attention is claim sent? \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

What is the address of the office where the Chiropractic claims are to be sent?

Name of company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

To whose attention is claim sent? \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

h. Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Plan # \_\_\_\_\_ ID # \_\_\_\_\_

2. Once your coverage is confirmed we will accept payment directly from the insurance company.

3. If you have any questions or problems, please direct them to the office staff.

\_\_\_\_\_

Date

\_\_\_\_\_

Time

\_\_\_\_\_

Patient's Signature