INSURANCE VERIFICATION FORM

Clear Form

Office Information:

Ressler Chiropractic Inc. NPI: 1740574847

Dr. David C. Ressler, DC TIN: 45-1603105

PRE-CALL (fill this top part out before your call so that all information is readily available)

Your Name _____ Social Security _____ D.O.B _____

Group # _____ Policy # _____

Insurance Company (IC) _____ Effective Date _____

IC Address _____ City _____ State _____ Zip _____

IC Phone _____ Fax _____ Email_____

DURING CALL

Insurance Rep Name _____ Rep ID? _____

POLICY BENEFITS:

Does this policy cover chiropractic services?	☐YES ☐NO
Does this policy cover manipulation of the spine?	☐YES ☐NO
Does this policy cover manipulation of arms or legs?	☐YES ☐NO
Does this policy cover examinations separate from chiropractic services?	☐YES ☐NO
Does this policy cover physical therapy?	☐YES ☐NO

Deductible? _____ How much met? _____ Ded. period Jan-Dec? ☐YES ☐NO

Co-payment? _____ Co-pay Max? _____

Is there a maximum # of visits covered (Max Visits)? _____

Is there a maximum $ dollar amount covered (Max $)? _____

Are there any Other Policy Limitations or Restrictions to Chiropractic?

Sign Your Name: Please Print Before Signing or Dating **Date: _____**

ONCE YOU HAVE CONFIRMED YOUR COVERAGE PLEASE FAX, OR SCAN AND EMAIL THIS FORM TO OUR OFFICE BEFORE YOUR NEXT APPOINTMENT OR JUST BRING IT IN WITH YOU IF THERE ISN'T A HURRY

Fax: 650-615-9069 Email: inbox@wbchiro.com

Print Form