MASCOTO CHIROPRACTIC, PLLC

FAMILY WELLNESS CENTER

519 CHOCTAW
MCALESTER, OK 74501
(918) 4BE-WELL

Verification of Insurance Benefits

Date _______________

Information on Patient: ID# ___________________ Group # ___________________
Patient's Name ___________________DOB __________ Sex ____ Marital Status _____
Address ______________________________ City ____________ State____ Zip____
Home Phone __________________________ SSN _____________________________
Occupation ___________________________ Employer__________________________

Information on Insured (If different): ID# ____________ Group # _______________
Insured's Name _________________________ DOB ___________ Sex __________
Address ______________________________ City ____________ State____ Zip____
Home Phone __________________________ Relationship ______________________
Employer_____________________________ Phone ___________________________

Information on Primary Insurance Policy:
Insurance Company ____
Address ________________________________ City ___________ State ____ Zip _____
Phone ____________________ Contact Person __________________________________

Is this an HMO or PPO plan? _______ Pay for out of network doctors? ______________
Is there Chiropractic coverage? __________
Amount of Deductible _______ Met Yet ______ Amount Left _____ Co-Pay _________
Pay for X-Rays? _________ Pay for Examinations? ________ Visit Limit _____________
Maximum Benefit? __________ Per Individual ___________ Per Family ____________

Information on Secondary Insurance Policy (If Applicable): ID# _________________
Insurance Company ____
Address ________________________________ City ___________ State ____ Zip _____
Phone ____________________ Contact Person __________________________________

Is this an HMO or PPO plan? _______ Pay for out of network doctors? ______________
Is there Chiropractic coverage? __________
Amount of Deductible _______ Met Yet ______ Amount Left _____ Co-Pay _________
Pay for X-Rays? _________ Pay for Examinations? ________ Visit Limit _____________
Maximum Benefit? __________ Per Individual ___________ Per Family ____________

COPY FRONT AND BACK OF ALL INSURANCE CARDS!

Information on Patient: ID# ____________________ Group # ____________________
Patient's Name ____________________DOB __________ Sex ____ Marital Status _____

Information on Primary Insurance Policy:
Insurance Company ____
Phone _____________________ Contact Person __________________________________

Is this an HMO or PPO plan? _______ Pay for out of network doctors? ______________
Is there Chiropractic coverage? __________ (MM only) Cross-over?________________
Amount of Deductible _______ Met Yet ______ Amount Left _____ Co-Pay _________
Pay for X-Rays? _________ Pay for Examinations? ________ Visit Limit ____________
Maximum Benefit? __________ Per Individual ___________ Per Family ____________
How much of the Max Benefit or visit limit has been met?__________________________
Is the max benefit or visit limit being met during the deducatble?___________________
Does this policy renew annually or anniversary?__________________________________

Is there a Physical therapy benefit, when done by a Chiropractor?___________________
Deductible__________ Met Yet_____________ Amount left_______Co-Pay__________
Maximum Benefit?_____________ Visit Limit_______________

Information on Secondary Insurance Policy (If Applicable): ID# _________________
Insurance Company ____
Phone _____________________ Contact Person __________________________________

Is this an HMO or PPO plan? _______ Pay for out of network doctors? ______________
Is there Chiropractic coverage? __________
Amount of Deductible _______ Met Yet ______ Amount Left _____ Co-Pay _________
Pay for X-Rays? _________ Pay for Examinations? ________ Visit Limit ____________
Maximum Benefit? __________ Per Individual ___________ Per Family ____________

Information on Patient: ID# ____________________ Group # ____________________
Patient's Name ____________________DOB __________ Sex ____ Marital Status ______

Information on Primary Insurance Policy:
Insurance Company ____
Phone _____________________ Contact Person ___________________________________

Is this an HMO or PPO plan? _______ Pay for out of network doctors? ______________
Is there Chiropractic coverage? __________
Amount of Deductible _______ Met Yet ______ Amount Left _____ Co-Pay _________
Pay for X-Rays? _________ Pay for Examinations? ________ Visit Limit ____________
Maximum Benefit? __________ Per Individual ___________ Per Family ____________

Information on Secondary Insurance Policy (If Applicable): ID# _________________
Insurance Company ____
Phone _____________________ Contact Person ___________________________________

Is this an HMO or PPO plan? _______ Pay for out of network doctors? ______________
Is there Chiropractic coverage? __________
Amount of Deductible _______ Met Yet ______ Amount Left _____ Co-Pay _________
Pay for X-Rays? _________ Pay for Examinations? ________ Visit Limit ____________
Maximum Benefit? __________ Per Individual ___________ Per Family ____________