FAMILY WELLNESS CENTER

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

## **Verification of Insurance Benefits**

Date			
<b>Information on Patient:</b> ID#	Group #		
Patient's Name DOB	Sex	Marital	Status
Address			
Home Phone			
Occupation			
<b>Information on Insured (If different):</b> ID#_	Gr	oup #	
Insured's Name		_	
Address			
Home Phone			
Employer			
Insurance CompanyAddress		State	 Zip
Insurance Company			
Phone Contact Person	_ City	State	<b>Z</b> ıp
1 Holle Contact 1 C150.			
Is this an HMO or PPO plan? Pay for	out of network do	octors?	
Is there Chiropractic coverage? Amount of Deductible Met Yet			
Pay for X-Rays? Pay for Examinat			
Maximum Benefit? Per Individua	ıl Per	r Family	
Information on Secondary Insurance Policy	(If Applicable): I	D#	
Insurance Company			
Address	City	State	Zip
Phone Contact Person	n		
Is this an HMO or PPO plan? Pay for	out of network do	octors?	
Is there Chiropractic coverage?			
Amount of Deductible Met Yet	Amount Left _	_ Co-Pay	V
Pay for X-Rays? Pay for Examinat		isit Limit _	
Maximum Benefit? Per Individua			

**COPY FRONT AND BACK OF ALL INSURANCE CARDS!** 

<b>Information on Patient:</b>	ID#		Group #				
Patient's Name		DOB	Sex	Marital Status			
<u>Information on Primary Insurance Policy</u> : Insurance Company							
Insurance Company							
Phone	Con	itact Person					
Is this an HMO or PPO pla	an?	Pay for out	of network doc	etors?			
Is there Chiropractic cover	:age?	(MM	only) Cross-ov	er?			
Amount of Deductible	Met	Yet A	Amount Left	Co-Pay			
Pay for X-Rays?	Pay for	Examinations	s? Vi	sit Limit			
Maximum Benefit?							
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 ann							
Is there a Physical therapy	benefit. v	hen done by a	Chiropractor?				
Deductible Me		•					
Maximum Benefit?							
		V 1510 2311110		-			
<b>Information on Secondar</b>	ry Insurai	nce Policy (If	Applicable): II	O#			
Insurance Company	-						
Phone							
Is this an HMO or PPO pla			of network doc	etors?			
Is there Chiropractic cover							
Amount of Deductible	Met	Yet A	Amount Left	Co-Pay			
Pay for X-Rays?							
Maximum Benefit?							
				<u> </u>			

<b>Information on Patient:</b>	ID#	# Group #						
Patient's Name								
Information on Primary Insurance Policy:								
Insurance Company								
Phone	Contact Pers	on						
Is this an HMO or PPO pla		or out of network d	loctors?					
Is there Chiropractic cover		. T. C	G. D.					
Amount of Deductible			•					
Pay for X-Rays?	_ Pay for Examin	ations?`	Visit Limit					
Maximum Benefit?	Per Individu	ıal P	Per Family					
Information on Secondary Insurance Policy (If Applicable): ID#								
Insurance Company								
Phone								
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 Examin	ations?	Visit Limit					
Maximum Benefit?	•							