Insurance Authorization Statement (In Forms)

Patient Name: _____ **DC:** _____

SS#: _____ **Date of Birth:** _____

Name of Insured: _____ **Insured's Employer:** _____

Insured's SS#: _____ **Insured's DOB:** _____

Insurance Company: _____

Policy/Member ID#: _____ **Group#:** _____

OFFICE USE ONLY

If United HealthCare – Check Group # if needs to be submitted to ACN directly? (Y / N)

Billing Address: _____ **City**_____ **St**_____ **Zip**_____

Chiropractic Cov? (Y) (N) Effective Date:_____/_____/_____ **CoPay: $**_____ **or**_____**%**

Contracted Office Visit Rate: _____**% Can benefits be paid directly to the provider? (Y / N)**

Is there a maximum that will be paid per visit? (Y / N) How much? $_____ **Max Visits/Year?** _____**/yr**

Deductible: $_____ **Met $**_____ **Is there a separate Chiropractic deductible? (Y / N)**

What is the coverage period? Calendar Year? (Y / N) Other? Dates: _____

Do deductible visits count towards the visit maximum? (Y / N) Are X-Rays Covered? (Y / N)

Referral of Primary Care Physician Req'd? (Y/N) Preauthorization Req'd? (Y/N) Other Restrictions (Y/N)

What are they? _____

Other: _____

Phoned by: _____ **Date:** _____

Disallowed Procedures:

❑ No Restrictions

❑ I understand that some visits/charges may not be covered by my insurance. Reasons visits may not be covered include refusal of authorization by my carrier, and also may include those visits that go beyond the maximum number of visits allowed by carrier. I accept full financial responsibility for such visits, and understand that I will be responsible at the current "underinsured" cash rate ($65 or $125 if exam)

❑ Please note that there is a fee of $45 for any missed or cancelled appointment(s) without 24 hours notice.

❑ Co-payments, co-insurance and/or deductibles are due at the time of service.

❑ I understand/hereby acknowledge that a certain portion of my care may not be covered by my HMO/PPO, insurance company or health plan under the terms of my Benefit Plan. Non-covered services may include soft tissue massage therapy (97124 or A9270), supplements, medical equipment, and supplies. My acknowledgement below indicates that I have been advised of this information and agree to be responsible to self-pay for these services.

I understand that my coverage as explained above is NOT A GUARANTEE OF PAYMENT and that this service was provided to me as a courtesy only. I further understand that any disputes that arise over my coverage are between the insurance company and me and that ultimately, I am responsible for payment in full of the services rendered me here, whether or not the company pays as stated above.

_____ _____

Signature ***Date***