Insurance Verification Form

Dr. Michael T Martin
NPI 1699907170
Tax ID 27-0504565

Phone: (832) 916.7642

Fax: (832) 518.1599

Patient: _____ Patient's Date of Birth: _____

Patient's SS# _____Member Number _____

Insured Name: _____ Insured's Date of Birth: _____

Insured's SS #: _____Unique ID #: _____

Patient's Zip Code _____Relationship:_____Self _____Spouse ____Child _____Other (Specify) _____

Date of Injury/Onset:_____Chief Complaint: _____

Insurance Company:_____ Plan: _____

Insurance Company Phone Number:_____

Claim/GroupNumber:_____

Network _____ In_____ Out _____Employer _____

Effective Date:_____Termination Date:_____

Individual Deductible:_____ Family Deductible _____ Amt Met: Individual _____

Amt Met: Family _____Out of Pocket Amount:_____Amt Met: Ind: _____Family_____

Copay: _____ Co-Insurance Amount_____ Carry Over _____

Benefit Year:_____LifeTime Max:_____ PCP : _____

X-Rays _____ Diagnostic/Lab Testing _____ Pre-Existing _____

Chiropractic Covered: _____ Yes _____ No Referral Required: _____ Yes _____ No _____Verbal _____ Written

Dollar Limit per year:_____Dollar limit per visit:_____Procedures per visit: _____

Manipulations:_____Office visit:_____Modalities:_____

Number of visits:_____ Visits used:_____ Physical Therapy:_____

Claims Address:_____

City,St.Zip: _____

Electronic Payor Number:_____

PreCert Phone#: _____ Fax #: _____

Additional Comments:

Insurance Representative_____:_____Ref # _____

PM Staff member: _____Date _____

A quote of benefits is not a guarantee of payment. Benefits are determined when the claim is processed at the carrier. I understand it is my responsibility to know what my policy covers. If the insurance determines my benefits are different from this quote, the insurance determination will apply and my responsibility will be based on the insurance determination

Patient Signature _____ Date _____