Insurance Questionnaire

Payment in full at time of service will be expected until this completed form is returned.

1. Your name ________________________________ Today's date____________________

2. Name of insurance co.____________________________ Phone # _____________________

   INSURANCE ID NUMBER _________________________________DATE OF BIRTH____________

3. Does my policy have any benefits for chiropractic care? **Y** **N**
   If YES, what are the limits to the coverage?________________
   Annual number of visits #_______________
   Annual maximum benefit $_____________
   For children: Age limit on adjustments? **Y** **N** ***If YES***, what age is it? ______________
   If BCBSMA, is a review required after 12 visits? **Y** **N**

4. How many visits have been used so far this year? ______________

5. What chiropractic services are covered under my plan? Initial Office Visit **Y** **N**
   Spinal Adjustments? **Y** **N** Adjunctive Therapeutics **Y** **N** X-Rays **Y** **N**

6. Is there an annual deductible? **Y** **N**
   If YES, How much is it? $_______________
   How much of the deductible has been met so far this year? $__________
   When does the policy year begin? January 1st? Other date___________
   When do the benefits renew? January 1st? Other date____________

7. Is there a copayment or coinsurance due each visit? **Y** **N**
   If YES, How much is the copayment or coinsurance? $____________

8. Is a referral needed? **Y** **N**
   If YES, by whom? __________________________(e.g. primary care doctor)

9. Is there an IN NETWORK or OUT OF NETWORK difference to the copayment/coinsurance, deductible, or benefit? **Y** **N**
   If YES, What are the differences?
   IN NETWORK: Co-pay/co-ins______ Deductible ______ Reimbursement __________
   OUT OF NETWORK: Co-pay/co-ins _____ Deductible_____ Reimbursement __________

10. Is Dr.Lewis in the network? **Y** **N**

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