Fairfield Spine and Rehab Center, LLC

E-Z Patient Insurance Verification

Step #1 Patient Information Account # _____

Patient Name:_____ DOB:_____/_____/_____

If spouse/legal guardian carries the insurance plan, complete the following

Spouse's/Legal Guardian's Name:_____ DOB:_____/_____/_____

Insurance Company:_____

Step #2 Insurance Company Information (call or obtain information online)

1) Is Dr. James DePietro, DC covered with my insurance plan? **YES** **NO**
2) Effective date of policy:_____/_____/_____
3) Is this a **calendar** year or **benefit** year policy from _____ to _____? (circle one)
4) What is the deductible? $_____ Has the deductible been met? **YES** **NO**
5) Is a referral from a family physician required? **YES** **NO** If yes, please provide the name of your primary care physician._____
6) Is authorization from the insurance company required to be seen? **YES** **NO**
7) Is there a co-pay due for each visit? **YES** **NO** How much? $_____
   If no co-pay, is there a co-insurance? _____% (Example: 80/20 or 70/30)
8) How many manipulation visits to my chiropractor are covered? _____
   If no specified number of manipulation visits, are there unlimited visits? **YES** **NO**
9) How many modalities/physical therapy sessions are covered? _____
   If no specified number of modalities/physical therapy, are there unlimited visits? **YES** **NO**
10) If not managed by number of visits is my coverage determined by a set dollar amount for the calendar year/benefit year? $_____
11) I **do not have** any chiropractic benefit coverage. ☐
12) Is pre-certification required for additional testing (XRAY, MRI, CT Scan) completed by an outside facility? **YES** **NO**
    PRE-CERTIFICATION PHONE number to call is: (_____)-_____-_____
13) Are orthotics covered under my plan? **YES** **NO** If yes, is pre-certification needed? **YES** **NO**
    PRE-CERTIFICATION PHONE number to call is: (_____)-_____-_____ **Billing code L3020**

Patient Signature X_____Date X_____