

Southerland Chiropractic
3206 Manvel Rd.
Pearland, Texas 77584
Phone: (281) 997-8788 Fax: (281) 997-8797

Verifying Chiropractic Benefits

Spoke with: _____ Date: _____ Time: _____

Patient: _____ Date of Birth: _____

Policy Holder: _____ Date of Birth: _____

Policy holder's ID# or SS#: _____ Group#: _____

Insurance Co.: _____ Network: _____

Send claims to: _____
Address City State Zip

Phone #: _____ Effective date: _____

Is Dr. Dale Southerland **in** or **out** of network? _____

IN NETWORK

Type of Plan? Indemnity HMO Self-Funded PPO POS Other _____

Do I have a deductible for chiropractic care? **Yes** or **No**

If yes, how much is my deductible? _____ How much has been met? _____

Does my deductible have a carryover to the next year? **Yes** or **No**

Out of pocket? _____ How much out of pocket met? _____

Does my deductible count towards my out of pocket? **Yes** or **No**

Does my policy have Pre existing conditions? **Yes** or **No** If yes, dates? _____

Do I have an office co-pay for initial visit? **Yes** or **No**

If yes, what is my co-pay? _____ Does this include x-rays and exam? **Yes** or **No**

Do I have a co-pay each time I receive a manipulation? (not billed with an office visit) **Yes** or **No**

If yes, what is my fixed co-pay? _____

If no, what % does the insurance cover? _____

Do I have any limits? **Yes** or **No** (based on medical necessity)

If yes, \$ amount per year _____ any met? _____

(Or)

If yes, # of visits per year _____ any met? _____

(Or)

If yes, maximum insurance will pay out per visit? _____ any met? _____

Do my benefits run according to: Calendar year? **Yes** or **No**
If no, then what are the dates for the plan year? _____

Do my limits start after the deductible is met? **Yes** or **No** (begins on the first date of service)

Does my plan require a referral from my Primary care physician? **Yes** or **No**

NOTE: If yes, please contact your PCP for a referral.

Do my chiropractic benefits include therapy? Ex. 97010 (Hot/cold packs), 97014 (muscle stimulation), 97112 (neuromuscular re-education)? **Yes** or **No**

If no, do I have a separate therapy deductible? \$_____ any met?

_____ Co-pay? _____ # of visits allowed per year? _____ any met? _____

OUT OF NETWORK

Type of Plan? Indemnity HMO Self-Funded PPO POS Other_____

Do I have a deductible for chiropractic care? **Yes** or **No**

If yes, how much is my deductible? _____ How much has been met? _____

Does my deductible have a carryover to the next year? **Yes** or **No**

Out of pocket? _____ How much out of pocket met? _____

Does my deductible count towards my out of pocket? **Yes** or **No**

Does my policy have Pre existing conditions? **Yes** or **No** If yes, dates? _____

Do I have an office co-pay for initial visit? **Yes** or **No**

If yes, what is my co-pay?_____ Does this include x-rays and exam? **Yes** or **No**

Do I have a co-pay each time I receive a manipulation? (not billed with an office visit) **Yes** or **No**

If yes, what is my fixed co-pay? _____

If no, what % does the insurance cover? _____

Do I have any limits? **Yes** or **No** (based on medical necessity)

If yes, \$ amount per year _____ any met? _____

(Or)

If yes, # of visits per year _____ any met? _____

(Or)

If yes, maximum insurance will pay out per visit? _____ any met? _____

Do my benefits plan run according to: Calendar year? **Yes** or **No**

If no, then what are the dates for the plan year? _____

Do my limits start after the deductible is met? **Yes** or **No** (begins on the first date of service)

Does my plan require a referral from my Primary care physician? **Yes** or **No**

NOTE: If yes, please contact your PCP for a referral.

Do my chiropractic benefits include therapy? Ex. 97010 (Hot/cold packs), 97014 (muscle stimulation), 97112 (neuromuscular re-education)? **Yes** or **No**

If no, do I have a separate therapy deductible? \$_____ any met?

_____ Co-pay? _____ # of visits allowed per year? _____ any met? _____