Insurance Verification Worksheet

Fill out before you call:	
Insurance Co.	Insurance phone #
Patient Name	DOB
Subscriber/Policy #	Group #
Effective Date	Expiration Date

Beginning of call:	
Date of call	Representative name
Time call begIn AM / PM	Representative phone #/extension/ID#
Time call end AM / PM	
Electronic Payer ID#	Accept Electronic Claims? YES / NO
Waiting Period Met? YES / NO	Insurance cycle date

Details:	
Chiropractic Benefits? YES / NO	
Pre- authorization necessary? YES / NO	
Limits on visits per year? # per year _____ $ per year _____	
Codes covered?	
72083 97010 97012 97014	
97032 97035 97110 97112	
97140 98941 98943 99212	
Any specific codes not covered?	
Co-pay amount? In Network _____ Out of Network _____	
Out of Network Deductible:	
Individual	Met
Family	Met
In Network Deductible:	
Individual	Met
Family	Met

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This worksheet is a courtesy of:

Glencoe Family Chiropractic 1011 Hennepin Ave N Glencoe, MN 55336
Phone 320-864-8000 FAX 320-864-8004