Dr Stephanus P. E. Boshoff D.C. **Dr. Carisa S. E. Novak D.C.**

BOSHOFF CHIROPRACTIC CENTER

INSURANCE VERIFICATION FORM

HERE IS THE INFORMATION YOU NEED TO VERIFY YOUR INSURANCE COVERAGE:

Your Legal Name (As it appears for this Insurance Co.): _____
NAME of your insurance company _____
DATE you called the insurance company_____
NAME of the person who gave you the information_____
CALL your insurance company and ask the following questions:

1.Does my policy cover *Chiropractic?* Yes___ No___
2.If yes are there any limits to my coverage? Yes___ No___
3.What are those limits? (Be as specific as possible):
_____
4.Will they cover a cervical pillow? Yes___ No___
5.Nutritional supplements? Yes___ No___
6.Structural supports? Yes___ No___
7.Is there a limit to the number of visits allowable? Yes___ No___
8.What is the **deductible**? _____
9.Is it yearly? Yes___ No___
10.Has it been paid? Yes___ No___
11.If yes, how much? _____
12.What percentage of my bills will my policy cover? _____%
13.What is the **effective date** of my policy? _____
14.Can benefits be assigned to my Chiropractor's office? Yes___ No___
15.What is the address of the office where the claims are sent?
_____
_____
_____
16.To whose attention is the claim sent? _____
17.**TELEPHONE NUMBER** of my insurance company _____
18.**POLICY NUMBER** _____
19.**INDIVIDUAL POLICY** _____
20.Is this a group policy? Yes___ No___ Group #_____
21.**NAME** policy is under _____
22.Please check the one that applies.
Major Medical___
Industrial Accident/Work-Comp. ___
Personal Injury ___
23. Group Number _____

1100 W GONZALES ROAD, SUITE 101,OXNARD,CA. 93036.TEL(805)485-4339 FAX(805)485-6042