Insurance Pre-Approval Form

Entry Date: ____________________

Patient's Name: ______________________________ Phone: ____________________

Social Security No.: ______________________________ Date of Birth: ____________________

Employer: ______________________________ Phone: ____________________

Referring Physician: ______________________________ Phone: ____________________

Date of Injury: ______________________________

Insured's Name: ______________________________ Phone: ____________________

Social Security No.: ______________________________ Date of Birth: ____________________

Insurance Company: ______________________________ Phone: ____________________

Street Address: ____

City: ______________________________ State: __________ Zip: ______________

Policy #: ______________________________ Plan #: ____________________

Claim #: ______________________________ Member #: ____________________

Group #: ______________________________ I.D. #: ____________________

Type of Insurance: ❑ Group ❑ PIP/Auto ❑ Workers' Compensation

Effective Date of Policy: ______________

Is There A Deductible? ❑ Yes ❑ No Amount: ____________________

Is The Deductible Met? ❑ Yes ❑ No Amount Remaining: ____________________

Co-Pay Amount: ______________________________ Maximum # of Visits: ____________________

Maximum Dollar Amount: ______________

Percentage Policy Pays for the Following Services:

Office Visit _____ Acupuncture _____ Massage _____ Physiotherapy _____ Counseling _____

Chiropractic _____ Supports _______ X-Rays _____ Physical Therapy ___ Vitamins _______

Adjuster's Full Name:

Phone #: ______________________________ Extension #: ____________________

Time and Date of Call: ____

Approved For: ____

Send: ❑ Notes: ____________ ❑ Rx: ____________________ ❑ Interim Report: __________

❑ Initial Report: ________ ❑ Progress Report: __________