Patient self-verification Insurance Information

Patient name: _____
Policyholder (name on insurance card) _____
Policyholder's date of birth _____

Name of Insurance: BlueCross BlueShield (in-network)
ID # _____
Group # _____
Customer service phone number (back of card) _____

Date called: _____ Time: _____ ***Provider NPI: 1194939603***

Customer service representative's name: _____

Individual Deductible _____ **Family deductible** _____
Amount of deductible remaining: _____
Out-of-pocket maximum: _____

Co-pay $_____
Patients co-insurance _____%

Office visit benefits including x-rays

Insurance pays _____%

Chiropractic benefits

Visit max _____ used _____
Dollar max _____
Insurance pays _____%

Physical therapy benefits

Visit max _____ used _____
Dollar max _____
Insurance pays _____%

Acupuncture benefits

Visit max _____ used _____
Dollar max _____
Insurance pays _____%