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: _____