ADVANCED WELLNESS CENTER OF PA
Alternative Solutions to Chronic Health Problems

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INSURANCE VERIFICATION FORM

PLEASE LEAVE BLANK ANY UNKNOWN INFORMATION 1

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: Home: _____ Cell: _____

Social Security #: _____

Name of Insured: _____ Relationship to Patient: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Type: ❑ Group ❑ Private ❑ Work Comp ❑ Auto Accident

Policy #: _____ Group #: _____

Claim #: _____ Adjuster: _____

Date of Accident/Injury: _____ Adjuster Phone #: _____

FOR OFFICE USE ONLY 2

WC Claim _____ Open? ❑ Yes ❑ No

MVA Claim _____ Open? ❑ Yes ❑ No

Chiropractic Coverage? ❑ Yes ❑ No

Chiro Co-Pay _____ Deductible $ _____ Met _____

Visits allowed/ P.T. _____ Manipulation _____

Diagnostic Testing/Designated Site? _____

DME/Designated Supplier? _____

Comments _____

_____

_____

_____

Phone # Called: _____ Spoke to: _____ Date/Time: _____

Navinet Used: _____ Date: _____

Attorney: _____ Phone #: _____