**Sage Chiropractic Incorporated - Dr. Delores Bussie**


# *Insurance Verification*

Patient Name: _____

Patient Address: _____

MUST INCLUDE ZIP CODE: _____

Patient Phone #: _____

Patient Date of Birth: Male: _____Female: _____

Patient, Subscriber # / ID #: _____

Group #: _____

Insured Name & ID # (if different from patient): _____

Relationship to Insured: Single _____ Married _____ Other _____

Insurance Company Name: _____

Insurance Company Phone #: _____

Claim # if an accident: _____

Date of Accident Injury: _____

Other Info: _____

***To Be Completed By Office Staff:***

NO Coverage: _____ Coverage: _____
Deductible $ _____Amount Met$ _____
Acupuncture YES I NO Units I Visits _____
Office Visit - YES I NO Allowable % _____
P I T - YES I NO Units I Visits _____
Visits Per Year _____ Other _____

**PLEASE FAX BACK TO (561) 799-0263**