Date: _____

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient _____ SS# _____ DOB _____
Insured Name_____ Policy ID#_____ Relation to Insured_____

PLEASE SELECT FROM SECTIONS BELOW & CHECK ONLY *ONE* STATEMENT THAT APPLIES TO YOUR INSURANCE COVERAGE – YOU MUST SIGN THAT SECTION:

Self:

_____ I am the patient AND the insured AND I have no other insurance coverage

_____ _____
Authorized Signature Date

Spouse / Partner:

_____ I am the patient, BUT the insured is my spouse/partner _____. I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am employed at _____ but have no coverage through that employer.

_____ I am the patient & have my own coverage - the following is my coverage information:
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Dependent Child (In school): (covered under parent's policy)

_____ I am a student & have 1 policy. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____

_____ I am a student & have 2 polices. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Dependent Child Under (Not in school): (covered under parent's policy)

_____ I am a dependent on the policy and only covered under this policy :
Primary Ins _____ Insured Name: _____ Insured DOB: _____

_____ I am a dependent and covered under two policies :
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Revised 5/12/13

Date: _____

Dear Insurance Carrier:

I, _____, am currently receiving services at _____. Please know that this care is ***not related*** to any auto accident, workers' compensation injury or any other type of injury, which would render a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

_____
Print Name

_____ _____
Signature Date