

# Chiropractic Life Center, P.C. Insurance Information

## 1. PRIMARY INSURANCE

Please give your Insurance card to the Receptionist

Insurance Company Name \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
\_\_\_\_\_

Are you the primary card holder?  Yes  No

*If you answered "No" Please complete the following information*

**Please note all information below is required for insurance billing.**

Insured's Name ( Last, First, MI) \_\_\_\_\_

**\*Person who is primary on the insurance.**

Relationship to Patient \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Insured's Social Security number \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's ID Number \_\_\_\_\_

Male  Female

Insured's Mailing Address if Different from Patient Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insured's Phone if Different from Patient Phone Number \_\_\_\_\_

( ) - \_\_\_\_\_

## 2. ADDITIONAL INSURANCE

Please give your Insurance card to the Receptionist

Insurance Company Name \_\_\_\_\_

Insured's Group# (Plan, Local or Policy #) \_\_\_\_\_

Insured's ID Number \_\_\_\_\_

Are you the primary card holder?  Yes  No

*If you answered "No" Please complete the following information*

**Please note all information below is required for insurance billing.**

Insured's Name ( Last, First, MI) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Insured's Social Security number \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's ID Number \_\_\_\_\_

Male  Female

Insured's Mailing Address if Different from Patient Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insured's Phone if Different from Patient Phone Number \_\_\_\_\_

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Chiropractic Life Center, PC, or insurance company to release any information required in order to process my claim(s).

**Patient  
Signature** \_\_\_\_\_

**Date** \_\_\_\_\_