CAPITOL CHIROPRACTIC CENTER

INSURANCE INFORMATION FORM

Questions for Patient:

Name of Insurance Company: _____

Address for Claims Submission:_____

Phone Number:_____

Group Number:_____

Policy Number: _____

Questions for Insurance Company:

Effective Date of Coverage: _____

Deductible Amount: _____

Has the deductible been met?_____

Insurance % : _____

Patient % / Co-pay: _____

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