WE INSERT YOUR LOGO HERE

Patient Name : **test 1 test 2** **Insurance** : **Cigna**

Date : **8/11/2021**

Verification of correct policy number and group number	ID 1234567 is valid and Group number 0000XXX is valid
Policy effective dates and current status of patient's policy.	Patient's policy effective from 01/01/2019 to current as primary (Calendar year plan)
Type of policy and services covered	PPO Plan
IE(Initial eval) considered part of treatment Yes/No	Yes
Co-pay	PT, Chiro, Acu $10.00 copay for in network No copay for out of network
Co-insurance	PT, Chiro, Acu No Coins for In network PT, Chiro, Acu 20% Coins for out of network
Deductible and how much the patient has already satisfied in the deductible period	PT, Chiro, Acu In network deductible will not apply PT, Chiro, Acu Patient's annual year deductible for Out of network individual is $100.00 and met $60.00(This is a individual plan)
Out of pocket expense (Family and individual)	PT, Chiro, Acu Patient's annual year out of pocket for In network individual is $400.00 and met $90.00(This is a individual plan)

	PT, Chiro, Acu Patient's out of pocket maximum for out of network individual is $2000.00 and met $90.00(This is a individual plan)
Can Chiro and PT done on the same day (YES/NO)	Yes
Benefit Limitations / Visit Limitation	Based on Medical Necessity
Paper claim mailing address phone number	P.O. Box XXXX, NJ 12345 Phone 1234567890
Requirement for pre-authorization / referrals	Prior Authorization is not required Referral is required from PCP Dr. John Phone number: 1234567890
Timely filing limitations for claim filing	1 year from date of service
Date of call	8/25/2021
Caller	Ben
Call Reference # (Provided by the Payer)	"Id123456 Representative: Jack"

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered. I understand that the benefit verification is not a guarantee of claims reimbursement. I understand that the insurance company may deny the claim and it is my responsibility to understand my benefits and my financial obligations. If the insurance company does not reimburse the clinic, I may be responsible for the services rendered, in part or in whole.

Signature : _____

Date : _____

The disclaimer above, and footer will be customized to your clinic. We will provide a PDF like this, for each benefit verified. Your practice should obtain the patient's signature and retain a physical copy for your own records.