EXTENDED HEALTH BENEFITS

CHECK-OFF LIST

Name: _____ Date: _____

We have prepared this list for you, to help you get **ALL** the information you need when you call for your Work Extended Health Benefits. We have included questions for all of the services we offer in our office.

Do you have Extended Health Benefits through your work or school? Yes No
Does your spouse, mother or father have Extended Health Benefits through his/her work?
☐Yes ☐No (if no you are done with form)

INFORMATION TO RECORD **BEFORE YOU CALL:**

Your work Insurance Company – Name: _____ Phone# _____

Employer: _____ Employee: _____

Employee ID#: _____ Group Policy#: _____

INFORMATION TO GET **WHEN YOU CALL**:

Is there a deductible ☐ Yes-How much? $_____ ☐ No
Is this a family plan ☐ Yes ☐ No
Is your limit:☐ per calendar yr. ☐per fiscal yr. _____to_____☐ per 12 consecutive months

DO YOU HAVE **CHIROPRACTIC** COVERAGE? ☐ Yes ☐ No

What is your limit per year? $_____
What is your limit per visit? $_____
Do you have x-ray coverage?☐ Yes ☐ No – Is it included in your maximum? ☐ Yes ☐ No

DO YOU HAVE **MASSAGE THERAPY** COVERAGE? ☐ Yes ☐ No

What is your limit per year? $_____
What is your limit per visit? $_____
Do you need a referral ☐Chiropractor ☐M.D. ☐ No

Do you have **CUSTOM ORTHOTICS** COVERAGE? ☐ Yes ☐ No

What is your limit per year$_____
How many pairs can you order? _____
Do you need a referral ☐ Chiropractor ☐ M.D. ☐ No
Do you get one pair per year or every second year? _____

OTHER ITEMS TO CHECK ON:

Do they cover orthopaedic cervical pillows? ☐ Yes ☐ No
Do you have coverage for COMPRESSION HOSIERY OR STOCKINGS? ☐ Yes ☐No
What is your limit per year? $_____

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