Chauvin Chiropractic Clinic
1000 Wildcat Drive
Abbeville, LA 70510
(337) 893-5252

The following questions are necessary so that we may properly file your insurance for you. These questions are directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare _________ Medicaid _________ Champus _________ CampVA___________
   Group Health Plan _________ Other ________ Insured's ID Number ______________
2. Patient Name ____
3. Insured's Name (as it appears on insurance card) ____
4. Patient's Address ____
   City _______________________________ State _______ Zip _________ Tele # ______________________
5. Insured's Address (if appears same as patient put "same")____
   City _______________________________ State _______ Zip _________ Tele # ______________________
6. Patient Status (circle one): Single Married Other
   Employed: Full-Time Student Part-Time Student
7. Other Insured's Name (If applicable): ____
   Other Insured's Policy or Group Number: ____
   Other Insured's Date of Birth: ___________________________ Male ____________ Female _____________
   Employer's Name or School Name: ____
   Insurance Plan Name or Program Name: ____
8. Is the condition we are treating related to current or previous employment? Yes ___________ No __________
9. Is the condition we are treating related to an auto accident? Yes _____________ No _____________
10. Is the condition we are treating related to another type of accident? Yes _____________ No _____________
11. Insured's Policy Group or FECA Number: _____________________________________
    Insured's Date of Birth: _____________________________ Male _____________ Female _____________
    Employer Name or School Name: ____
    Insurance Plan Name of Program Name: ____
12. Is there another health benefit plan? Yes _____________ No _____________ If Yes, List
    ____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: ____ Date: ___________________________

Insured's Authorized Person's Signature: I authorize payment of medical benefits for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: ____ Date: ___________________________

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes _____ No _____
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes _____ No ______
3. Is the illness of injury the result of an accident or illness that occurred at work? Yes _____ No _____
4. Is the illness or injury the result of an accident of other injury? Yes _____ No _____
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes _____ No _____
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes _____ No _____
7. Do you have a Medicare Medigap Policy? Yes _____ No _____ Name of Company __________________________
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes _____ No _____