



SMART SOLUTIONS. HEALTHY RESULTS.

Patient Eligibility verification

Provider Name:

Return Fax #:

Circle One (applicable to provider): DC ND LAc LM

Date:

Patient relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Information

Insured Information

Name:

Name:

Address:

Address:

Date of Birth:

Date of Birth:

Phone Number:

Phone Number:

Contact Person:

Contact Person:

Insurance Carrier:

Plan name:

Member ID Number:

Group Number:

Effective Date of Coverage:

Termination Date:

Co-pay:

Co-pay required for x-rays:

Deductible:

Has the deductible been met?

When is another deductible due?

Co-insurance:

Percent paid by plan:

Dollar Limit (annual?):

Visit Limit (annual?):

Is a referral required?

Referral telephone number:

Treatment extension request required?

Pre-authorization required?

Mail to: The CHP Group, PO Box 278 Beaverton, OR 97075-0278 **OR Fax to:** 503-203-8522