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