

Requested Information

Date: _____

Statement of Non-Accident

I, _____, am currently receiving chiropractic care at this facility. Please know that this care is **not related** to any auto accident, worker's compensation injury or any other type of injury in which there is a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

Print Name

Signature

Coordination of Benefits Statement

Name of Patient _____

SS# _____ DOB _____

Name of Policy Holder _____

Policy ID# _____

Relation of Patient to Insured _____

If the patient is a dependent:

Is dependent a full time student? _____

Is dependent insured by any other insurance policy? _____ Please explain (including name of carrier) _____

If the patient is a spouse:

Is the spouse employed? _____ Where _____

Is spouse insured through that employment _____ Please explain (including name of carrier) _____

Print Name

Signature