VERIFICATION OF MEDICAL PAY COVERAGE

SCHROEDER FAMILY CHIROPRACTIC
2535 N. FRESNO
FRESNO CA. 93703
(559) 226-2535
(FAX) 226-7266

Date:_____________________

This is to verify that___________________________________
(Policy holder or patient)
is covered by____
(Insurance carrier name)

Insurance Address:____________________________________
City:_________________State:________Zip Code:__________

For accident date of:__________________________________

Policy #:____
Claim #:____

Amount of coverage available:____________________________

Please return to our office, as soon as it is completed.

Thank you.