INSURANCE VERIFICATION FORM

PLEASE CALL YOUR INSURANCE COMPANY AND COMPLETE THIS FORM BY ASKING THE FOLLOWING QUESTIONS:

Patient name: _____Date of call:_____ Time: _____

Spoke to: _____ Insurance Company: _____

Phone # (_____) _____ Insured:_____ Insured's DOB_____

Relationship to the patient: _____ Policy#:_____Group#_____

1. Is Acupuncture covered on this plan? **Acupuncture**⍑Yes /⍑No

2. Is a referral required from my Primary Care Physician for Acupuncture? **Acupuncture**⍑Yes /⍑No

3. Is pre-authorization required?⍑Yes /⍑No

4. Am I limited to specific diagnosis codes?⍑Yes /⍑No

5. If yes, does one of these codes apply to your illness?⍑Yes /⍑No

6. Are there any limitations for pre-existing conditions?

7. Is there a deductible?⍑Yes /⍑No
   If yes, what is the deductible? $_____ How much has been met? $_____

8. Is there a maximum yearly benefit for Acupuncture? **Acupuncture**⍑Yes /⍑No

Is that per⍑Calendar Year /⍑Fiscal year /⍑Renewal Date?

Acupuncture
#_____ of visits⍑per year /⍑per diagnosis /⍑per incident
#_____ of visits used year to date
$_____ of Acupuncture care per year
$_____used year to date

9. What percentage is covered? Acupuncture _____%

10. Is there a co-payment or leftover percentage that I am responsible for?⍑Yes /⍑No
    If yes, what is it? $_____

11. Are benefits for other forms of alternative health care (Chiropractic, Massage, Naturopathic, Physical Therapy, Mental Health Counseling) taken from the same pool as Acupuncture/Massage?⍑Yes /⍑No

***Please note, benefits stated by a representative cannot be guaranteed.**