ACUPUNCTURE MEDICAL INSURANCE VERIFICATION

Patient's Name: ____

SS# (if applicable): _______-_______-___________ DOB: ____/____/_______

HEALTH INSURANCE:

Insured/Subscriber's Name: ____

SS# (if applicable): _______-_______-___________ DOB ____/____/_______

Member #: _____________________ Group #________________ Effective: ___/___/_____

Employed By: ____________________________

Name of Insurance Company: ____

Billing Address: ___________________________________ City:________________________

State: ______ Zip Code: ________________ Phone #: ( ) _____-________

Acupuncure Covered: ____Y / N__ Can you be treated by a Licesned Acupuncturist? __Y / N__

Deductible Amount: $_________ Has it been met? ____Y / N__ How much is left? $_______

LIMITS:

Maximum amount: $_________ Max. amount of visits/year ______ Combined w/ Chiro? _Y / N__

Are there any exclusions on what conditions can be treated? _____Y / N__

List (if yes):

____

Any other applicable information:

____

Spoke with: __________________________________ Date: ________________

WORKER'S COMPENSATION:

Name of Insurance Company: ____

Billing Address: ___________________________________ City:________________________

State: ______ Zip Code: ________________ Phone #: ( ) _____-________

PLEASE TURN OVER

Claim #: ____________________ DOI: ____/____/_____ Dates Valid: ________to_________

Employer: ____

Adjuster Name: ____________________________________ Phone #: (   ) ______-_________

Written Authorization: ______Y / N__

Referring Physician: _________________________________ Phone #: (   ) ______-_________

Verification Done By: _______________________________ Date: ___________________

PLEASE TURN OVER