



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 Co: _____ Phone #: _____

Insured: _____ Relation to Patient: _____

Policy #: _____ Group #: _____

1. Is Acupuncture covered on this plan? Yes / No
2. Is a referral required from my primary care physician? Yes / No
3. Is pre-authorization required? Yes / No
4. Am I limited to specific diagnosis codes? Yes / No
(If yes, does one of these codes apply to your illness? Yes / No)
(If no, stop here)
5. Is there a deductible? Yes / No
If yes, what is the deductible? \$ _____
How much has been met? \$ _____
6. Is there a maximum yearly benefit for Acupuncture? Yes / No
Is that per calendar year / fiscal year / renewal date?
_____ # of visits per year. _____ # of visits used year to date.
\$ _____ of acupuncture care per year. \$ _____ used year to date.
7. What percentage is covered? _____ %
8. Is there a co-payment or leftover percentage that I am responsible for?
Yes / No If yes, what is it? \$ _____
9. Does my plan cover herbal prescriptions? Yes / No
10. Are benefits for other forms of alternative health care
(Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture?
Yes / No

Claims Address: _____ City: _____

State: _____ Zip: _____

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



Consent to use and disclosure of health information for health insurance companies

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:

X _____
 Patient Signature or Legal Representative Date Witness Signature

Office Use Only:

Accepted _____
 Denied Signature Title Date