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:_____

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

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

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

Massage
#_____ 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 _____% Massage _____%

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.**