INSURANCE VERIFICATION FORM

Complete this part of the form BEFORE calling your insurance provider.

Insurance Company Name: Phone Number:

Date of Call:

Patient Name: Patient Address:

Patient Date of Birth: Patient Gender:

Patient SSN:

Policy Holder Name:

Policy Holder Date of Birth:

Policy Holder SSN:

Member ID:

Group #:

Who am I speaking with? Recorded Call Reference#:

Does my policy cover acupuncture treatment?

What conditions are covered? What conditions are excluded?

What is the allowable dollar amount per visit?

How many visits are allowed per (calendar year?) (contract year?)

Does reimbursement for acupuncture start right away or after I have met my deductible?

Do non-reimbursed visits count towards my deductible?

What is my deductible and how much have I met toward it to date?