INSURANCE VERIFICATION SHEET

Please fill out the following form to collect and verify insurance coverage. (You may call the provider yourself if you choose to do so.)

Insurance Company *Name*

_____

Insurance Company Claim Submission *Address*

_____

Customer Service Phone Numbers

_____

Name of Person Insured on the Plan

_____

Your Relationship to the Insured (Self, Spouse, or Other?)

_____

Patient Membership No._____ Group Policy No_____

Patient Date of Birth_____ Social Security No _____

Employer_____

Employer Address_____

Employer Phone _____

QUESTIONS TO ASK INSURANCE REPRESENTATIVE

*It is **very important** that all of the following questions are asked **to ensure coverage.** Remember insurance companies are **in the business of not paying if they can get around it.***

Has my ***deductible been met?***_____ ***How many*** acupuncture treatments are allowed on this plan?_____

Who may perform these treatments? _____

May a ***licensed acupuncture physician perform*** these treatments?_____

What **kinds of diseases** may by treated with acupuncture ***for coverage?*** _____

_____

_____

_____

Will you cover acupuncture treatments performed by a physician ***out of network?***_____

What percentage of the acupuncture treatment will you cover?_____