OUT OF NETWORK INSURANCE VERIFICATION

YOUR NAME: ___________________________ ___ DATE OF BIRTH: _____________________________

INSURANCE NAME: __________________________ PHONE#: ____________________________________

INSURANCE ID: ______________________________ INSURANCE EFFECTIVE DATE: __________________

CLAIMS ADDRESS: ____

NAME OF INSURANCE REPRESENTATIVE: ________ CALL ID OR REPRESENTATIVE ID:________________

Do I have out of network benefits? _____________________ Y or N

If there are no out of network benefits then you will not have any coverage for your treatment

If yes:

What is my deductible? ________________ Has any of this been met?_______________________

Does my insurance offer end of year roll over? ___________

What is my copay or percent that is covered once deductible is met? _______________________

What is the maximum amount of visits I can have? ___________

What is the maximum dollar amount that can be covered? ____________

What is the maximum dollar amount for out of pocket? ______________

Do I have exam coverage? _____________________

Do I have specialty testing coverage? ________________

Will any supplements be covered? _________________

ACUPUNCTURE COVERAGE: Y or N and do you have a website for acupuncture coverage?

If yes: Does treatment need to be done by a MD or LAc? ____________

What are my Acupuncture treatment limits?

# of visits _____ $ maximum_____ #of days_____ etc._____

Is notification, pre-authorization or a referral needed before treatment? Y or N

If yes: What do I need to do? ____

Do I have coverage for physical medicine and rehabilitation by an acupuncturist? Y or N

Do I have coverage for a physical medicine and rehabilitation by an out of network primary care physician? Y or N

Are there limits or provisions on the policy that I have not inquired about?

____

TODAY'S DATE: ___________

YOUR NAME IF NOT PATIENT: _____________________

If you have secondary insurance please follow the same protocol with them.