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INSURANCE VERIFICATION FORM

Patient's Name (printed):____

Date of Birth: ______________________________ Today's Date: ___________________________

Please have the following information when calling your insurance company:

1) Insurance company's phone number (on the back of your card): ______________________________

2) Policy Holders name (if different from patient): ____________________________________

Please obtain and verify the following information with regard to your Acupuncture Coverage. We cannot process your claim without this information. Thank you.

1) Does my policy cover acupuncture? [Y] or [N]. If NO, you are done with this form.

2) Ask for the name of the person giving you this information: ______________________________

3) Continue to verify type and amount of coverage:

   a. What is the yearly deductible: Per Person: ________________ Per Family: _________________

   b. How much of the deductible has been met this year: ______________________________

   c. Is there a co-pay? [Y] or [N]. If so, how much?______________________________

   d. If there is no co-pay, what is the percentage that the company covers?_______ And what % is the member responsible for ______________? Does this apply before the deductible is met? [Y] or [N]. If YES, does the coverage % change after the deductible is met, [Y] or [N]? If YES, what is the amount covered after the deductible is met? __________________________

   e. Is there a limit to the number of visits or $ amount? [Y] or [N]

   f. If YES, how many visits are allowed and/or what is the $ limit? ______________________

   g. Are services limited to injury only? [Y] or [N]. If NO, what else is acupuncture covered for? (ex. Asthma, Nausea related to chemo, etc) ______________________________

   h. Is a Referral or Pre-Certification form required [Y] or [N]? If YES, who fills out the form? _______ How can we obtain the form? ______________________________

   i. What is the effective date of the policy (a specific date or per calendar year)? ______________

   j. Does the policy cover the following Acupuncture codes (circle the codes that apply): 97810 (acu), 91811 (acu, additional 15), 97813 (acu, w e stim), 97814 (acu with e stim additional 15), 20552 (injection), 97140 (Myofascial release), 97799 (cupping/ moxibustions), 99201 (Initial eval), 99213 (re-exam)

   k. Policy holder's employer: __________________________ ID# __________________________

   l. Group # (if applicable to your policy): ______________________________

Name and address of the insurance office where the claims are sent:

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Thank you for obtaining and verifying this information with your insurance company. We expect they will reimburse you or your account as noted above.

Insurance is a contract between the insured (patient) and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

PLEASE READ ALL THE FOLLOWING INFORMATION TO CLARIFY INSURANCE PROCEDURES.

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover acupuncture services. If acupuncture services are covered, the amount and type of reimbursement varies according to the policy that has been purchases by you or your employer. (see reverse for details)

If you have determined that your insurance will cover your care in our office, we will bill them directly. If you prefer, we will give you a statement at the end of your first week and then once a month after that, if you want to bill on your own behalf. When you send in your statements, your insurance company will reimburse you directly. They are responsible to you, as the subscriber, not to us, the provider. You can utilize the "Insurance Verification Form" (on the back of this form) when you inquire about your coverage.

EXEPTIONS:
If your insurance requires direct billing from us, we will supply them with the necessary information to remit payment to our office on your behalf. Please understand that you're responsible to pay for all services not covered by your insurance company including deductibles, co-payments and any other balances not reimbursed by the insurer.

NOTE:
You must verify the type and amount of coverage before we can submit claims on your behalf. On the reverse side of this form is an "insurance verification form" that will assist you in obtaining all the vital information needed for us to accept and submit bills to your insurance. Until we receive this information, your account will be on a cash basis.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLETE ALL FORMS NECESSARY TO ALLOW ENLIVEN ACUPUNCTURE LL TO ASSIST ME WITH INSURANCE REIMBURSEMENT. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL SERVICES RECEIVED SHOULD MY INSURANCE FAIL TO REMIT PAYEMENT.

Patient Name Printed: ____

Patient Signature: ______________________________________ Date: ______________________