VERIFICATION OF INSURANCE COVERAGE FOR ACUPUNCTURE

Name: _____ Date: _____

Here is what you do to verify coverage for Acupuncture care. Fill out this form completely (one for each insurance company you have coverage with) and return to our office on your next visit.

DATE you phoned your insurance company: _____
NAME of the Insurance Company: _____
TELEPHONE NUMBER of Insurance Company: _____
NAME of company representative you speak with: _____

1. CALL your Insurance Company and ask the following questions:

a.Does my policy cover Acupuncture? Yes____ No____
If no, how can I get it included on my policy? _____
If yes, are there any limits to my coverage? Yes____ No____
What are those limits (Be as specific as possible).
_____
Is there a limit to number of visits allowable? Yes____ No____ If yes, how many _____
Is there a maximum payment per treatment? Yes____ No____ What?_____
Will it cover a pre-existing condition? Yes____ No____ If yes, under what conditions ____
_____
Will it cover Acuscope? _____ TENS?_____ Herbs? _____
How does your company code these (it varies from company to company)? _____
_____
What procedure code does your company accept for Acupuncture? _____
Is coding by RVS or CPT standards? _____
Do I need an M.D.'s or D.C.'s prescription for Acupuncture? Yes____ No____ Other ____
Explain: _____

b.What is the DEDUCTIBLE? _____ Is that yearly? Yes____ No____
Per condition? ____ Per family member? ____ Per total family ____.
Has the deductible been paid? Yes____ No____ If yes, how much? _____

c. What PERCENTAGE of the charges will my policy cover? _____%.
It is initially _____% until $ _____ is reached and then _____% up to $ _____
What percentage is covered on accidents? _____%

d. What is the EFFECTIVE DATE of my policy? _____

e. Can benefits be assigned to my Acupuncturist's office? Yes____ No____

f. What is my CLAIM NUMBER? _____

g. Do you require reports for payment of Acupuncture? Yes____ No____
If yes, how often?_____
What kind of report, if applicable: Short Form___ Initial ___ Interim Re-evaluation ___ Final ___
Other_____
Does your company pre-authorize payment for report? Yes____ No____

h.. What is the ADDRESS of the office where claims are to be sent? _____
_____

i. To WHOSE ATTENTION is the claim sent?_____

j. PHONE NUMBER of Insurance Company Claims Department _____
Do you accept electronic billing? Yes____ No____ If yes, what phone number and other information does the office need to do this? _____
_____

k.POLICY #: _____ GROUP # _____
INSURED's S.S.# _____
NAME policy is under _____
Employer's Name & Address _____
_____
_____
_____

2. Obtain an Insurance form from your agent or place of employment. Fill-in the required personal information COMPLETELY. Write n/a for all questions not applicable. Attach our insurance billing form to a COPY of the insurance claim form.

3. THIS FORM MUST BE BROUGHT INTO OUR OFFICE COMPLETELY FILLED IN BEFORE WE CAN INITIATE A THIRD PARTY PAY SYSTEM. UNTIL THEN, FULL PAYMENT IS DUE ON THE DATE OF SERVICE.

4. PLEASE NOTIFY us when your insurance company changes.

If you have any questions please phone our office for assistance. We are happy to answer any questions you may have.

I state that the above answers are true and correct.

Signature _____

Date: _____