

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 be 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? _____