



## ACUPUNCTURE INSURANCE VERIFICATION FORM

### TO BE COMPLETED BY THE CLIENT

Patient Name:	Date of Birth:
Address:	City/State:
Phone:	Zip Code:
Your Insurance Id #:	
<b>SUBSCRIBER INFORMATION:</b>	
Name:	Relationship to Client: CIRCLE ONE
Address:	Self          Spouse          Parent
City/State: ZIP Code:	Do you have a Referral from your Primary Care Physician? Yes          No
Phone:	

### TO BE COMPLETED BY THE OFFICE

Acupuncture Coverage:    Yes          No	ID#
Referral Needed:            Yes          No	Child Coverage if Minor    Yes          No
In or Out of Network Benefits or Limits:	

Deductible Amount: \$	How much met: \$
Deductible Period:	Verified By: Date:

Acupuncture Diagnosis Requirements: Pain, Nausea, Osteoarthritis, etc.:
Acupuncture Treatment Limits: # of visits, \$ cap, # of days, etc.:
Additional Information: Are there any other limits or provisions on this policy that I have not inquired about?

UPDATED 1.2011

MAKE COPY OF PATIENT'S INSURANCE CARD (FRONT AND BACK), KEEP ALL CORRESPONDENCE IN THIS FILE.