Date:_____

PATIENT INSURANCE INFORMATION

Primary Insurance: _____Ins. Plan_____

ID:#_____ Group#:_____

Name of Patient:_____ Date of Birth:_____

Insured's Name:_____ Date of Birth:_____

Relationship to Patient: _____

Employer of Insured: _____

Secondary Insurance: _____Ins. Plan_____

ID:#_____ Group#:_____

Name of Patient:_____ Date of Birth:_____

Insured's Name:_____ Date of Birth:_____

Relationship to Patient: _____

Employer of Insured: _____

_____

OFFICE USE ONLY

POLICY BENEFIT VERIFICATION: Date:_____

Ins & Phone#: _____

Verified By / Ref#: _____

Acupuncture by LAc: Yes / No Referral Needed: Yes / No

In Network Benefits pays: _____

Co-pay / Office visit _____

Deductible Amount: $_____ How much met: $_____

Diagnosis Requirements: Pain, Nausea, Childbirth, etc:_____

Treatment limits: # of visits, $ cap, etc: _____

Additional information: _____