

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: _____