sahm ACUPUNCTURE HEAVEN | EARTH | HUMANITY

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Insurance Verification Form

Please call your insurance company and complete this form by asking the following Questions, keep a copy for your records and please bring a copy with you when you meet with your acupuncturist.

Patient Name:_____ DOB: / /

Date of call:_____ Time:_____ Spoke to:_____

Insurance Co.:_____ Phone#: _____

Claims Address:

Fax #:_____

Insured: _____ Relationship to patient: _____

Policy # _____ Group #/ID#: _____

Please circle the answers below:

1. Is acupuncture covered on this plan? Y / N ( ) In NETWORK ( ) Out of NETWORK
2. Can Acupuncture be performed and billed by a Licensed Acupuncturist? Y / N
3. Is a referral required from my primary care physician? Y / N .
4. Is a LETTER OF MEDICAL NECESSITY required? Y / N . Is pre- authorization required? Y / N
5. Am I limited to specific diagnosis codes? Y / N (If **NO,** stop here.)

(if **YES**, ask " what diagnosis codes will insurance cover?- Please list some of the codes)

6. Are modalities billed counted towards the Physical Therapy cap? Y / N
7. Is there a deductable? IN NETWORK $_____ out of NETWORK $_____

(How much has been met as of date:_____? $_____)

8. Is there a maximum yearly benefit for acupuncture? Y / N
   A. Is that per Calndar year? / Fiscal Year? / Renewal Date? / /)
   B. _____ # of visits per year? / per diagnosis? / per incident?
   C. _____# of visits used year to date
9. What percentage is covered? Out of NETWORK? ____%
10. Is there a co- payment I am responsible for? Y / N
11. Are the following CPT codes accepted? – Please circle the codes accepted.

97810 97811 97813 97814 97026 97140 99203 00202 99213 97039

REMARKS: