ABUNDANT HEALTH ACUPUNCTURE & HERBS
Diane L. Smalley, L.Ac.
750 Central, Willits, CA 95490
707.456.9514
California License AC 2644

VERIFICATION OF INSURANCE COVERAGE FOR ACUPUNCTURE

This form MUST be filled out COMPLETELY and returned to us before we can bill your insurance company for our services. Until then, full payment will be required at the time of service. For most health insurance, there will be a percentage of charges not covered for which payment will be required at the time of service. BRING this completed verification form to the office.
Please NOTIFY US when your insurance coverage or employment changes.

Patient's name _____ Date of injury/onset _____

Type of injury/pain _____ Is it due to work? _____

If the insured person is other than the patient, please fill in the following information:

Name of insured person (if different from patient) _____

Patient/Insured's employer's name _____

Insured's address (same?) _____
street city state zip

Insured's date of birth _____ Home phone _____

Relationship to insured _____
Type of insurance: (circle) Group health through employer / Auto medical pay / Work Comp / HMO / other:

Is there more than one policy that covers the patient? Yes / No
If so, what is that company?

PLEASE READ AND SIGN BELOW
Authorization to release information: I authorize the release of any medical or other information necessary to process this claim. A photostat of this authorization shall be as valid as the original.

Patient's or guardian's signature _____ Date _____

Assignment of insurance benefits: I authorize payment of medical benefits directly to Diane L. Smalley, L. Ac. for the services described on the attached insurance claim. A photostat of this authorization shall be as valid as the original.

Patient's or guardian's signature _____ Date _____

CALL YOUR INSURANCE COMPANY AND ASK THEM THE FOLLOWING QUESTIONS:
(You may find some of this information on your card.) (Red items are essential.)

Date called _____ Phone # _____

1. Name of person who gave information? _____

Does my policy cover acupuncture? (circle) Yes No

If not, stop here.

If yes, continue:

2. Full name of insurance company? _____

Name of insurance plan? _____

Mailing address for claims? _____
street or P.O. Box

_____
city state zip Attn:

ID Number? _____ Group Number? _____

(Auto accident)Claim Number? _____ Other? _____

What is the effective date of my policy? _____

3. Is authorization required prior to treatment? (circle) Yes No

If so, what are their special phone numbers or departments to call? _____

_____

Name and number of person in charge of my claims (if applicable, e.g., attorney in cases of auto accident)?

_____

Are there any reports required from the acupuncturist and how often? _____

4. **(Insurance companies usually pay either a *Maximum* or a *Percentage* of the treatment.)**

Is there a Maximum payment per treatment **OR** do you pay a Percentage?

(circle) **Maximum** (see a. below) **Percentage** (see b. & c. below)

a.) If a **maximum** per treatment, what amount? $ _____

b.) If a **percentage** is paid, how much is it? _____ %

c.) Does the **percentage** change? (circle) Yes No

5. What is the deductible amount? $ _____ Is that per year? $ _____ –**OR**–

Per condition? $ _____ –**OR**– Per family member? $ _____

How much of the deductible has been paid? $ _____ (Remainder is $_____)

6. Are there any limits to the coverage? (circle) Yes No

Is there a limit to the number of visits allowable? (circle) Yes No

If so, what are they? (circle) per year per diagnosis other _____

Are there any other limits? _____

7. Do you send payment directly to my acupuncturist with authorization? (circle) Yes No