ACUPUNCTURE INSURANCE VERIFICATION FORM

TO BE COMPLETED BY THE CLIENT

Patient Name:	Date of Birth:
Address:	City/State:
Phone:	Zip Code:
Gender: CIRCLE ONE Male Female	
SUBCRIBER INFORMATION:	
Name:	Relationship to Client: CIRCLE ONE Self Spouse Parent
Address:	Do you have a Referral from your Primary Care Physician? Yes No
City/State: ZIP Code:	Provider: Your Insurance ID#:
Phone:	Insurance 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, Osteoarthrosis, 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 6.2012

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