NPI:

Insurance Verification

Caller___________________________ Call Date ________________ Time:______________

Before Calling Name ___________________________________ Birthdate _____________

Social Security Number _______________________ Member ID__________________________

Insurance Carrier ___________________________________ Group Number_________________

Insurance Phone Number ____________________________

Call Information Call Reference # _________________________ CSR Name ________________

Does policy cover acupuncture? □ Yes □ No

Do they pay: □ In network □ Out of network

Effective Date____________ Deductible? ______________ Deductible Met?______________

Co-pay _________ Self insured plan? □ Yes □ No Referral Necessary? □ Yes □ No

Annual limits? ____________________________________ _______________________________
(Calendar year, fiscal year, lifetime, per condition) Is acupuncture combined with other therapy?

How much is used? ____________________

Specific Coverage Information

E/M codes covered? ____

Diagnosis Exclusions?____

Modalities covered? ____

Notes ____

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____

Patient Follow-up (please include dates): ____

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