PHONE VERIFICATION OF INSURANCE COVERAGE FOR ACUPUNCTURE

Date:___________ Time of Call:___________ Name of Representative:______________________

Insurance Company:_______________________ Phone #:_______________ Group #:___________

Patient Name:____________________________ Name of Insured:____________________________

Member ID #:_____________________ Patient D.O.B:____________ SSN:__________________

CALL INSURANCE COMPANY and say that you want to verify coverage for out-patient benefits for an out of network acupuncture provider.

QUESTIONS:

Does the Policy Cover Acupuncture?:___________ Disclaimer Read?: Yes_____ No_____

Effective Date:_________________ In Network:_________ Out of Network:__________

Deductible:_____________ How Much Met?:_______________ Co-Pay:_____________________

When is another deductible due?:________________ Dollar Amount per Visit:______________

Yearly Maximum Limits:____
(calendar year, fiscal year, lifetime, per condition & if acupuncture coverage is combined with other therapies, chiropractic, PT, etc.)

Percentage Paid:__________________ Yearly Limits Used:________________________
(Out of Network Usually Pays a Percentage)

Do You Pay for Herbal Therapy?_______ What is your timely filing?:________________________

Do You Cover Other Modalities?:______

97140 (Manual Therapy Techniques):_____ 97026 (Infrared):_____ 99213 (Established Patient E/M):_____

97110 (Therapeutic Procedure: Exercise, ROM, Flexibility):_____ 97112 (Neuromuscular Reeducation):_____

Mail Claims To:__________________________ Notes:____________________________________

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