UNION CENTER FOR HEALING

INSURANCE VERIFICATION FORM: optional

You can use the form if you would like to call your insurance to verify your benefits and eligibility prior to your visit.

Patient name: _____Insurance Company: _____

Date of call:_____ Time: _____ Representative spoken to:_____

Phone # (_____) _____ Name of primary policy holder_____

Relationship to the patient: _____Policy#:_____Group#_____

1. Is acupuncture covered on my plan? YES / NO Is massage covered on my plan? YES / NO

2. Acupuncture: Is a physician *referral* required? YES / NO

#_____ of visits / per year / per diagnosis / per incident? #_____ of visits used year to date

$_____ of Acupuncture care per year $_____used year to date

Do I have a: Co-Pay:$ _____Co-Insurance:_____

3. Massage: Is a physician *prescription* required? YES / NO Is a physician *referral* required? YES / NO

#_____ of visits per year / per diagnosis / per incident? #_____ of visits used year to date

$_____ of Massage care per year $_____used year to date

Do I have a: Co-Pay:$ _____Co-Insurance:_____

4. Do I have a *deductible* that has to be paid in full before my insurance covers my acupuncture or massage appointments? YES / NO

>**If yes** what is the deductible amount? $_____How much has been met so far? $_____

4. Is *pre-authorization* required? YES / NO For: Acupuncture Massage Both

5. Is the condition or diagnosis that I seek treatment for: _____covered by my insurance? YES / NO If not, what conditions or diagnoses are covered?_____

_____

6. Are there any limitations for pre-existing conditions? _____

7. Are benefits for other health care (Chiropractic, Naturopathic, Counseling; or therapies such as Physical/Speech/Occupational Therapy) taken from the same pool as Acupuncture/Massage? Yes / No

_____

**Please note: Insurance benefits stated by a representative are not guaranteed.*