

# ACUPUNCTURE INSURANCE COVERAGE VERIFICATION

Alderman Medical Acupuncture is pleased to assist our valued patients to utilize direct payment from their insurance companies. However, it is important that you understand that health and accident insurance policies are an arrangement between you, the insured, and your insurance carrier. You are personally responsible for all services rendered and charges incurred in our clinic. We expect payment in full when the services are rendered until your insurance information and coverage has been verified.

## INSURANCE VERIFICATION IS AS SIMPLE AS 1 - 2 - 3

1. Using this form, call your insurance carrier/company and answer **all the questions** outlined for you.
2. Return this completed questionnaire to our office and we will then verify this necessary information and then bill your insurance company directly. Please remember deductibles, co-payments, supplements and supplies will still be due at time of service if applicable.
3. Bring to our office a completed insurance form obtained from your agent or employer.

Please be aware that some insurance representatives might attempt to discourage any type of care and treatment. If the adjuster or claims representative denies you benefits always get the representatives name and request that they state their complete reason for denying benefits in writing. In addition, ask for the copy of your policy where it states the exclusion of acupuncture therapy or treatment.

INSURANCE CO. NAME: \_\_\_\_\_ Date of Call: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name of Ins. Representative: \_\_\_\_\_ Job Title: \_\_\_\_\_

### PLEASE ASK AND ANSWER THE FOLLOWING QUESTIONS

1 Does my policy cover Acupuncture? ( ) Yes ( ) No (if NO, why not?) \_\_\_\_\_

2. If YES, are there any limits to my coverage? ( ) Yes ( ) No If YES, what are those limits? (Be specific as possible)

LIMITS OR LIMITATIONS: \_\_\_\_\_

3. Is there a limit to the number of visits allowed? ( ) Yes ( ) No If YES, how many and in what time frame: \_\_\_\_\_

4. Do you cover electrical stimulation (CPT Code 97813) ( ) Yes ( ) No Nutritional & Herbal Supplements ( ) Yes ( ) No

5. Structural Supports and Braces? ( ) Yes ( ) No Do you cover cervical pillows? ( ) Yes ( ) No

6. What is my **DEDUCTIBLE**? \_\_\_\_\_ Is that yearly? ( ) Yes ( ) No

7. Has it been **paid/met**? ( ) Yes ( ) No If YES, how much? \_\_\_\_\_ Is there a carry over? ( ) Yes ( ) No

8. Is there a **family deductible**? ( ) Yes ( ) No

9. What **Percentage** of my bill will my policy cover? \_\_\_\_\_ % Do I have a co-payment? ( ) Yes ( ) No How much? \_\_\_\_\_

10. What is the **Effective Date** of my policy? \_\_\_\_\_

11. Can **Benefits Be Assigned** to my Acupuncturist's office? ( ) Yes ( ) No \_\_\_\_\_

12. What is the **Address Where Claims Are Sent**? (Remind them you're in Idaho.)

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

13. To **Whose Attention** is the claim sent? \_\_\_\_\_

14. **Phone Number** for Insurance Verification? A/C \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

15. **Insured's Policy Group or FECA Number**? (As required in Box 11 of 1500 Claim Form) \_\_\_\_\_

16. Is this policy number an Individual or Group? ( ) Individual ( ) Group

17. Name policy is under? \_\_\_\_\_

18. What is my / or the **INSURED'S I.D. NUMBER**? (As required in Box 1a of 1500 Claim Form) \_\_\_\_\_

**IMPORTANT:** All of the above questions must be answered. Obtain an Insurance Form from your agent or place of employment. Fill in the required personal information. Where applicable have your employer fill in the indicated sections. Then bring the form to our office. This questionnaire and your insurance form should be brought to our office ASAP. The sooner your coverage is confirmed the sooner we can accept payment directly from your insurance company and limit your out of pocket expenses.

We're here to help! If you have any questions or problems, please direct them to our office staff.

The above statements and answers are true. Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_