

Insurance Information Form

Please take a moment to complete this form in its entirety, and sign at the bottom.
This will enable smooth insurance billing and reimbursement for our office. Thank you!

Patient Information

| | | |
|-----------|---|-------------|
| Name: | Date of Birth: | Gender: M F |
| Address: | Phone (home): | |
| (zip) | Phone (work): | |
| Employer: | <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Other | |
| Email: | | |

Primary or Medical Insurance

| | |
|------------------------------|------------------------------|
| Plan Name: | ID # (include prefix): |
| Plan Address (back of card): | SS# (if different from ID#): |
| | Group #: |
| | Plan Phone# (back of card): |

****Insured's Information, if other than self:** (do not skip this section!)**

| |
|--|
| Name: |
| Address: |
| Date of Birth: |
| Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other |

PIP, L&I, or Secondary Insurance (complete this section if you have a work or auto injury)

| | | | |
|-----------------------------------|-------------------------------|---|--|
| Is your condition injury related? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, auto accident | <input type="checkbox"/> Yes, work related |
| Plan Name: | ID # or SS# (include prefix): | | |
| Plan Address (back of card): | Claim #: | | |
| | Adjuster: | | |
| | Date of Injury: | | |
| Name of Insured: | Plan Phone #: | | |

Plan / Coverage Details

| | | | | | |
|--|-----------------------|---|---|-----------------------------|---------------------------------------|
| Co Pay: \$ | | Orthotic coverage? | Yes | No | Limits: |
| Annual Deductible: \$ | Co-insurance payment: | | | | |
| Yearly Max for Prevention visits | \$ | Eligibility confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | # of visits: | | | |
| COVERAGE LIMITS | \$ AMOUNT | # OF VISITS | REFERRAL OR PRESCRIPTION NEEDED? | | |
| Naturopathic | \$ | # | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self Ref. OK |
| Physical Medicine | \$ | # | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self Ref. OK |
| Acupuncture | \$ | # | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self Ref. OK |
| Massage | \$ | # | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self Ref. OK |
| Have you gotten the needed referrals or prescriptions? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | I confirmed coverage with (name): |

Referring Physician's Name: _____ Phone: _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to Rebecca Andrews, ND, LAc, LMP. I understand that I am ultimately responsible for all fees incurred, (for instance, if my insurance coverage expires or denies payment). I take full responsibility for knowing my insurance coverage and limits, and will work toward the goal of helping Rebecca Andrews, ND, LAc, LMP to be fully reimbursed for her services.

Signature _____ Date _____