Los Altos Acupuncture Center

INSURANCE VERIFICATION FORM

This form is only required if you plan on using health insurance. To determine whether your insurance provider covers acupuncture and related services, please fax or mail this form to our clinic a few days before your visit so we can verify your eligibility.

Please print all information clearly.

Patient Name_____ Date of Birth_____

Cell Phone (_____) _____ Home Phone (_____)_____

Email_____

Policy Holder Name_____ Birthdate_____ Patient Relation to Holder_____

Policy Holder ID_____ Group ID_____ Effective Date_____

Insurance Provider_____ Insurance Phone (_____)_____

Insurance Provider Address (Billing)_____

Are your symptoms a result of ☐ Employment? ☐ Auto Accident? ☐ Other Accident?

If so, and you want to include your acupuncture visits in your claim, please provide your

Claim #_____ Contact Person_____

All fees for medical services are due at the time of visit unless previous arrangements have been made between Los Altos Acupuncture Center and your insurance provider. Insurance is considered a method of reimbursing the patient for fees paid to the health provider and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance provider. Note that all published prices reflect a courtesy discount for cash patients.

Signature_____ Date_____

**************************************OFFICE USE ONLY**************************************

Deductible (Individual/Family)_____Co-Pay_____

Paid_____ Max Coverage (Per Year)_____

Max Office Visit (Per Year)_____ Max Out of Pocket_____ In Network (YES/NO)

Other Specifics_____ Limits on Complaints/Diagnosis_____

Covered Treatments: Office Visit (99202) Acupuncture (97811/97810)

Date Verified by