



**ABUNDANT HEALTH ACUPUNCTURE & HERBS**  
**Diane L. Smalley, L.Ac.**  
**750 Central, Willits, CA 95490**  
**707.456.9514**  
**California License AC 2644**

## **VERIFICATION OF INSURANCE COVERAGE FOR ACUPUNCTURE**

This form **MUST** be filled out **COMPLETELY** and returned to us before we can bill your insurance company for our services. Until then, full payment will be required at the time of service. For most health insurance, there will be a percentage of charges not covered for which payment will be required at the time of service. **BRING** this completed verification form to the office.

Please **NOTIFY US** when your insurance coverage or employment changes.

Patient's name \_\_\_\_\_ Date of injury/onset \_\_\_\_\_

Type of injury/pain \_\_\_\_\_ Is it due to work? \_\_\_\_\_

If the **insured person** is **other** than the **patient**, please fill in the following information:

**Name of insured person** (if different from **patient**) \_\_\_\_\_

**Patient/Insured's employer's name** \_\_\_\_\_

**Insured's address (same?)** \_\_\_\_\_  
street city state zip

**Insured's date of birth** \_\_\_\_\_ **Home phone** \_\_\_\_\_

**Relationship to insured** \_\_\_\_\_

Type of insurance: (circle) Group health through employer / Auto medical pay / Work Comp / HMO / other:

Is there more than one policy that covers the patient? Yes / No

If so, what is that company?

### **PLEASE READ AND SIGN BELOW**

**Authorization to release information:** I authorize the release of any medical or other information necessary to process this claim. A photostat of this authorization shall be as valid as the original.

Patient's or guardian's **signature** \_\_\_\_\_ Date \_\_\_\_\_

**Assignment of insurance benefits:** I authorize payment of medical benefits directly to Diane L. Smalley, L. Ac. for the services described on the attached insurance claim. A photostat of this authorization shall be as valid as the original.

Patient's or guardian's **signature** \_\_\_\_\_ Date \_\_\_\_\_

**CALL YOUR INSURANCE COMPANY AND ASK THEM THE FOLLOWING QUESTIONS:**

(You may find some of this information on your card.) (Red items are essential.)

Date called \_\_\_\_\_ Phone # \_\_\_\_\_

1. Name of person who gave information? \_\_\_\_\_

Does my policy cover acupuncture? (circle) Yes No

**If not, stop here.**

**If yes, continue:**

2. Full name of insurance company? \_\_\_\_\_

Name of insurance plan? \_\_\_\_\_

Mailing address for claims? \_\_\_\_\_  
street or P.O. Box

city state zip Attn:  
ID Number? \_\_\_\_\_ Group Number? \_\_\_\_\_

(Auto accident) Claim Number? \_\_\_\_\_ Other? \_\_\_\_\_

What is the effective date of my policy? \_\_\_\_\_

3. Is authorization required prior to treatment? (circle) Yes No

If so, what are their special phone numbers or departments to call? \_\_\_\_\_

Name and number of person in charge of my claims (if applicable, e.g., attorney in cases of auto accident)? \_\_\_\_\_

Are there any reports required from the acupuncturist and how often? \_\_\_\_\_

4. (Insurance companies usually pay either a *Maximum* or a *Percentage* of the treatment.)

Is there a **Maximum** payment per treatment **OR** do you pay a **Percentage**?

(circle) **Maximum** (see a. below) **Percentage** (see b. & c. below)

a.) If a **maximum** per treatment, what amount? \$ \_\_\_\_\_

b.) If a **percentage** is paid, how much is it? \_\_\_\_\_ %

c.) Does the **percentage** change? (circle) Yes No

5. What is the deductible amount? \$ \_\_\_\_\_ Is that per year? \$ \_\_\_\_\_ **-OR-**

Per condition? \$ \_\_\_\_\_ **-OR-** Per family member? \$ \_\_\_\_\_

How much of the deductible has been paid? \$ \_\_\_\_\_ (Remainder is \$ \_\_\_\_\_)

6. Are there any limits to the coverage? (circle) Yes No

Is there a limit to the number of visits allowable? (circle) Yes No

If so, what are they? (circle) per year per diagnosis other \_\_\_\_\_

Are there any other limits? \_\_\_\_\_

7. Do you send payment directly to my acupuncturist with authorization? (circle) Yes No