Ling's Acupuncture Insurance Verification Form

Type: ( ) Primary ( ) Secondary ( ) Supplemental IN NETWORK? Y/N

Patient's Name:____ DOB ___________

Name of Insured:____ DOB ___________

Group #_________________________ Group Name_____________________________

Name of Insurance Company:_________________________ ID #__________________

Insurance Address:____

City:___________________________________ ST______ Zip_________________

Phone # ____________________________Fax #________________________________

This statement is regarding verification of your health insurance.
Based on your policy, your coverage consists of:
Deductible:____________Remaining:____________Amount Used:____________
Coverage consists of:________%__________ (once deductible has been met)
Per calendar year, you are allowed ________visits.

By signing this form you acknowledge the above information regarding your policy.
You understand and are aware that we will be sending all claims to your insurance company and you give us the permission to do so. Until we receive payment from your insurance company we will collect the full amount of services at the time services are rendered. Once payment has been collected from your insurance company we will credit the amount to your account.

If at any time you choose to file the claims on your own or wish for our office to discontinue submitting claims, you must give us written notice.

X____ ______________
Patient Signature Date

Office Use Only: