MOUNTAINTOP
ACUPUNCTURE & REHABILITATION

INSURANCE VERIFICATION

Please call your insurance carrier before your appointment and ask the questions below so that you are aware of your coverage. Please bring this form to your appointment with you.

Insurance Company _____

Patient Name _____

Date of Birth _____

ID # _____

Policyholder Name _____

Relationship _____ Date of Birth _____

Customer Service Number _____

Call date _____ Representative _____ Call reference # _____

Acupuncture coverage: Yes □ No □ Effective date _____

Questions To Ask for Verification

For participating insurance plans:

In network benefits: Copay _____ Co-insurance % _____

Deductible _____ Met? Yes □ No □ Balance _____

Visits per year _____ How many used _____

Pre-authorization or referrals required for any acupuncture procedures? Yes □ No □

Referring provider _____ Phone _____

Are there any limitations on services? _____

For non-participating insurance plans:

Out of network benefits: Copay _____ Co-insurance % _____ Deductible _____ Met? Yes □ No □

visits per year _____ How many used _____

Pre-authorization or referrals required for any acupuncture procedures? Yes □ No □

Referring provider _____ Phone _____

Are there any limitations on services? _____