Health Insurance Verification Form

Please verify benefits before your appointment to avoid surprises. Insurance companies can make changes at any time without notifying members or providers. If benefits are not verified before a visit, full payment is due at time of service. Also note that you and/or your insurance company may be billed multiple procedure codes for a visit.

Name:_____

Insurance Company:_____

Date Called: _____

Representative's Name: _____

1. **Call the member services phone number on your insurance card and ask for a customer representative.**

2. **Have your ID # and Group # available. (These can be found on the front of your insurance card.)**

3. **Tell the representative "I am calling about my Naturopathic benefits"**

4. **What is my insurance effective date? Calendar year?**

5. **Is my Naturopathic Primary Care Physician in-network?   Yes / No**

Or out-of-network? Yes / No

11.   Has my deductible been met? Yes / No

a.   How much has been met? _____

b.   How much is left? _____

12. What is my in-network deductible? _____

13. What is my out-of-network deductible? _____

14. What is my co-pay/co-insurance? _____

15. Is there a max dollar amount covered for Naturopathic/Alternative Care for the year? _____

16. What is the maximum number of visits covered for Naturopathic/Alternative Care for the year? _____

17. Is Extended Time (CPT code 99385/99395) covered? Yes / No

a.   What is the co-pay or co-insurance? _____

18. Is my Annual Exam (CPT code 99385/99395) covered? Yes / No

a.   Do I have a co-pay? Yes/No

b.   What is my co-pay or co-insurance? _____

19. Can my Naturopath, licensed as a Primary Care Provider in Oregon, order lab, imaging, and diagnostic tests? Yes / No

a.   Are there restrictions? Yes / No

b.   If so, what are they?
_____

20. Does lab/imaging tests go towards my deductible? Yes / No

a.   Is there a co-pay? Yes / No

b.   Is my deductible different for office visits, lab/imaging tests? Yes / No

c.   If so, how much for each?
_____

21. What is the patient responsibility for out-of-network lab/imaging tests?
_____

a.   Pre-deductible being met? _____

b.   Post-deductible being met? _____

c.   Do I need pre-authorization? Yes/No

       i.   If so, for which ICD-10 codes? _____

22. What is the patient responsibility for in-network lab/imaging tests?

a.   Pre-deductible being met? _____

b.   Post-deductible being met? _____

c.   Do I need pre-authorization? Yes/No

       i.   If so, for which ICD-10 codes? _____

23. Is there a preferred network lab? Yes/No (please circle below)

Legacy   Providence   Quest   OHSU   Other _____

28. Is there a preferred network for imaging? Yes/No (please circle below)

Legacy   Providence   Quest   OHSU   Other _____

I understand that it is my sole responsibility to call my insurance company to find out what my plan coverage is. I also understand that I am responsible for all charges not covered by my insurance company that I request or that are recommended to me by my provider. My provider is not liable for unexpected fees I may incur during my treatment at the clinic.

_____   _____

Printed Name   **Date**

_____

Signature