Insurance Verification Form

Patient Name _____ **Date of Birth** _____/_____/_____

Phone Number (_____) _____ - _____ **to inform you about your insurance benefits**.

Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Policy Holder's Name _____ **Date of Birth** _____/_____/_____

Employment status: ☐Employed ☐Retired ☐Unemployed ☐Student

***Fill in only if applicable.**

Your symptoms are a result of: ☐ Employment ☐Auto Accident ☐Other Accident

Your Claim Number_____

Adjustor's Name_____ **Adjustor's Phone Number**_____

PLEASE READ CAREFULLY AND SIGN THE FOLLOWING: I authorize the release of any medical or other information necessary to process claims submitted to my insurance company or the other responsible party. I also assign the payment of medical benefits directly to Five Branches University for services provided. I understand that I am fully responsible for my bill and that if attempts to collect payment from my insurance company / responsible party are not successful, I will remit the balance due upon notification.

Patient / Parent / Guardian SIGNATURE _____ **Date**_____/_____/_____

OFFICE USE ONLY:

Insurance Company_____ **Phone Number** (_____) _____ - _____

Member ID Number_____ **Group/Policy Number** _____

Acupuncture Benefits ☐Yes ☐No **Massage Benefits** ☐Yes ☐No

Effective Date _____/_____/_____

Maximum Number of Visits _____/Week _____/Month _____/Year _____/Condition

Maximum Payable _____%/Visit $_____/Visit $_____/Year $_____/Condition

Deductible Single $_____ Family $_____ ☐Waived **Met** Single $ _____ Family $_____

Patient Out Of Pocket Single $_____ Family $_____

Spoke with _____ **Tracking Number** _____

Verified by _____ **Date** _____/_____/_____ ☐Lytec ☐Chart Sticker

Notes (Including Pre-Auth, MD Referral, Benefits used to date, and other)

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