8330 SW 8th Street, Miami, FL 33144-4180 Tel: 305-551-1600 Fax: 305-264-6942

Patient Name:	DOB:
Primary Insurer Name:	Policy / Plan
Primary Insurer DOB:	ID #
	Group #

Insurance Company Name:
Insurance Phone #
Electronic Payer ID #
Date of Verification:

POLICY BENEFITS:

Timely Filing Requirement -

Acupuncture Coverage: Yes ☐ No ☐	MD: LAc:
Referral Needed: Yes ☐ No ☐	Minors: Yes ☐ No ☐
In or Out of Network Benefits or Limits:	

Deductible Amount: $	How much met: $
Deductible Period:	

Acupuncture Diagnosis Requirements: Pain, Nausea, Osteoarthrosis etc.
Acupuncture Treatment Limits: # of visits, $ cap, # days etc.:

Physical Medicine and Rehabilitation by Acupuncturist:

Additional Information: Are there any other limits or provisions on this policy that I have not inquired about?

Make copy of patient's insurance card (front and back); keep all correspondence in this file