



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

<b>Patient Name:</b>		<b>DOB:</b>
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 <input type="checkbox"/>	No <input type="checkbox"/>	MD:	LAc:
Referral Needed:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Minors:	Yes <input type="checkbox"/> No <input type="checkbox"/>
In or Out of Network Benefits or Limits:				

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

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

Physical Medicine and Rehabilitation by Acupuncturist:
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Additional Information: Are there any other limits or provisions on this policy that I have not inquired about?
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Make copy of patient's insurance card (front and back); keep all correspondence in this file