



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 <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?

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