Little ACUPUNCTURE

INSURANCE VERIFICATION **Date**_____

Patient Name: _____
Last Name, First Name

Patient Address: _____

City, State & Zip(Must Have)_____

Patient Phone #: _____

Patient Date of Birth: _____Male: ____ Female: _____

Patient, Subscriber # / ID #: _____

Group #: _____

Insured Name & ID# (if Different from patient) _____

Relationship to Insured:_____Self_____Spouse_____Child_____Other_____

Insurance Co Name: _____

Ins. Co. Phone #: _____

Claim # if an accident:_____

Date of Accident/ Injury:_____

Other Info: _____

To be completed by office staff: **Date Verified:**_____

Effective Date:_____ Spoke To:_____

Deductible $ _____ Amount met $ _____

Acupuncture Yes / No # of Visits _____ % allowed _____

PT Yes / No # of Visits _____ % allowed _____

Office Visit Yes / No

Insurance Company Address:_____

_____