

Ling's Acupuncture Insurance Verification Form

Type: () Primary () Secondary () Supplemental IN NETWORK? Y/N

Patient's Name: _____ S.S.# _____ DOB _____

Name of Insured: _____ S.S.# _____ DOB _____

Group # _____ Group Name _____

Name of Insurance Company: _____ ID # _____

Insurance Address: _____

City: _____ ST _____ Zip _____

Phone # _____ Fax # _____

FOR AUTO ACCIDENT ONLY: Please fill the above information and
Case or Claim # _____ Date of Accident: _____

This statement is regarding verification of your health insurance.

Based on your policy, your coverage consists of:

Deductible: _____ Remaining: _____ Amount Used: _____

Coverage consists of: _____ % _____ (once deductible has been met)

Per calendar year, you are allowed _____ visits.

By signing this form you acknowledge the above information regarding your policy.

You understand and are aware that we will be sending all claims to your insurance company and you give us the permission to do so. Until we receive payment from your insurance company we will collect the full amount of services at the time services are rendered. Once payment has been collected from your insurance company we will credit the amount to your account.

If at any time you choose to file the claims on your own or wish for our office to discontinue submitting claims, you must give us written notice.

X _____
Patient Signature Date

<u>Office Use Only:</u>
