**HOW DO I VERIFY MY INSURANCE BENEFITS?**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance** **Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance ID#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is up to you, the patient/representative/guardian, to determine insurance coverage. In order to ensure you are aware of your benefits we request that you go through the following procedure before your visit. Regardless of your insurance coverage, payment is due in full at time of service. Knowing your insurance coverage will give you an idea of what your reimbursement rate will be for the services that are rendered by Dr. Tamar Blau, ND. It is the patient’s responsibility to be aware of his/her coverage, as well as any deductible and maximums. Please follow the steps below to find out your benefits and eligibility.

First, call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

**Name of insurance representative**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_

1. Is Tamar Blau, ND, in network or out of network?

 1a. Do I have coverage to see an Out-of-Network Naturopathic Physician? YES / NO

 If yes, I have \_\_\_\_\_\_\_\_% coverage and a $\_\_\_\_\_\_\_\_ co-pay.

2. Beginning date of this year’s policy \_\_\_\_\_\_\_\_\_\_\_ Ending date of coverage \_\_\_\_\_\_\_\_\_\_\_

3. Do I need a referral from my primary care physician (PCP) to see a Naturopathic Physician?

 YES/ NO

4. Is there a limit to the number of visits I am able to have with a Naturopathic Physician? YES / NO

 If yes, what is the limit?\_\_\_\_\_\_

5. Is there a limit to the number of times a diagnosis code can be used by a Naturopathic Physician? YES / NO

6. Is there a limit to the type of diagnosis codes a Naturopathic Physician can provide? YES / NO

7. What are my benefits for the following services?

\*\*\*Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending upon whether the doctor is IN or OUT of Network with your insurance company and whether your plan includes Out-of-Network benefits.\*\*\*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Naturopathic:  | Acupuncture:  | Physical Therapy:  | Chiropractic:  | Massage: |
|  % Covered:\_\_\_\_\_  | % Covered:\_\_\_\_\_  | % Covered:\_\_\_\_\_  | % Covered:\_\_\_\_\_  | % Covered:\_\_\_\_\_  |
| Co-Pay/Co-Insurance\_\_\_\_\_\_\_  | Co-Pay/Co-Insurance\_\_\_\_\_\_\_  | Co-Pay/Co-Insurance\_\_\_\_\_\_\_  | Co-Pay/Co-Insurance\_\_\_\_\_\_\_  | Co-Pay/Co-Insurance\_\_\_\_\_\_\_  |
| Year Max\_\_\_\_\_\_\_  | Year Max\_\_\_\_\_\_\_  | Year Max\_\_\_\_\_\_\_  | Year Max\_\_\_\_\_\_\_  | Year Max\_\_\_\_\_\_\_  |

8. What is my deductible for the year, and have I met any part of that deductible?

 Yearly deductible \_\_\_\_\_\_\_\_\_ Amount met \_\_\_\_\_\_\_\_\_\_\_ When does it re-set?\_\_\_\_\_\_\_\_

9. Are any of the specialties listed above subject to deductible? YES / NO

 If so, which ones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Do laboratory services count toward my deductible? YES / NO

11. Are preventative visits considered differently than illness-related visits? YES / NO

 If so, which services are considered preventative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please be aware that this is not a guarantee of payment. If an insurance company gives you inaccurate information, they may not honor the benefits that were quoted.

I have verified my insurance benefits and listed them above. I understand that insurance billing is provided as a courtesy, and that I am responsible for all claims unpaid by my insurance company. I agree to pay for all services at the time of service.

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**Name (Please print. Include parent / guardian name if patient is a minor)**

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**Signature (Parent or guardian if patient is a minor)**

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Date