GET YOUR QI ON

Acupuncture Insurance Verification Form

Please fax to 760-806-1727 48 hours prior to first visit to avoid payment in full at time services are rendered.

Type: ( ) Primary ( ) Secondary ( )Supplemental In Network? Y/N

Patient's Name:_____ DOB_____

Name of Insured:_____ DOB_____

Group # _____ Group Name:_____

Name of Insurance Company:_____ ID #_____

Insurance Address (back of card):_____

City:_____ St:_____ Zip:_____

Phone Number:_____ Fax:_____

FOR AUTO ACCIDENT ONLY: Please fill the above information and

Case or Claim #_____ Date of Accident:_____

By signing this form you acknowledge the above information reguarding your policy and give consent to verify coverage.

X_____ Date:_____
Patient Signature

FOR OFFICE USE ONLY:

This statement is reguarding 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 calender year, you are allowed _____ visits.

Jessica Cole L.Ac.
760-500-1512