HEALING JOURNEY
ACUPUNCTURE AND WELLNESS

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Patient Insurance Eligibility

FOR OFFICE USE ONLY

Practitioner: ☐ Megan Conover, M.Ac., L.Ac. ☐ _____

☐ *Only Ins.* ☐ *Primary Ins.* ☐ *Secondary Ins*.

CLIENT'S NAME:_____ **DOB:**_____ / _____ /_____

Insured's Name (if not client):_____ **DOB**:_____ / _____ /_____

☐ *Spouse* ☐ *Parent* ☐ *Other:* _____

Insurance Co.:_____ **Ins. Co. Phone**: _____

ID#:_____ **Policy/Group #**: _____

Date of: ☐ Call to insurance company _____ / _____ /_____ ☐ Online eligibility lookup _____ / _____ /_____

Talked to/Reference #: _____

Clinic Employee Name:_____

ACUPUNCTURE BENEFITS

Effective_____ / _____ /_____Benefit Period _____ / _____ to _____ / _____

☐ Co-Pay $_____ ☐ Co-Ins._____% *[Insurance company covers at _____%]*

Deductible: ☐ No *(waived)* ☐ Yes $_____ Met? ☐ Yes ☐No (*How much has been paid?)* $ _____

Do tx applied to deductible count toward MAX allowable for benefit period? ☐ Yes ☐ No

MAX acupuncture allowed: ☐ Specific # Visits_____ ☐ $ Amt._____ ☐ Unlimited?

Is max for *combined* alt. services? ☐ No ☐ Yes (w/ ☐ Chiro ☐ Naturo ☐ Massage ☐ PT ☐ Other_____)

How much of max has been used for benefit period? ☐ #TX_____ ☐ $_____

Is Prior Authorization required? ☐ Yes ☐ No