

# Insurance Verification Form

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

Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_

1. Do I have Naturopathic coverage?

Yes                  No

2. Beginning date of coverage? \_\_\_\_\_

3. Ending date of coverage? \_\_\_\_\_

4. Do I need a referral from my primary care physician?

Yes                  No

5. Is the doctor I want to see (Dr. Beck or Dr. Messinger) an In Network or Out of Network provider? \_\_\_\_\_

6. Is there a Co-pay per visit?

Yes                  No

If so, how much is it? \_\_\_\_\_

7. What is the deductible for the year and has it been met?

Deductible \$ \_\_\_\_\_

Amount of deductible met so far \$ \_\_\_\_\_

Date \_\_\_\_\_

8. Does your insurance cover if a naturopath orders labs or X-rays? Cat scans or MRIs? Ultrasounds?

Yes                  No

9. Is there a deductible for labs and/or radiology?

Yes                  No

If so, what is it? \_\_\_\_\_