Resonance Acupuncture

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Basic Health Insurance Questionaire:

I am currently an in-network provider with **Regence**, **Aetna**, **Cigna**, **Uniform Medical**, **Corvel**, **Premera**, and **Lifewise** and will bill your insurance for the services that you receive. If you have a non-HMO Group Health plan that allows you to be covered out-of network, I can also bill your insurance. If you have one of these Health Insurance plans I recommend contacting them to find out what your benefits are for acupuncture, massage and manual therapy and then please also fill out the HELATH INSURANCE INTAKE FORM.

If you have a Health Insurance plan with a different provider I am considered out of network and my office is not set up to bill your insurance company. However, I can give you a receipt with the information your insurance company requires so that you may submit to be reimbursed through your health insurance.

Call and ask your insurance company the following detailed questions, or you can find the answers on your Insurance company's web page. It is important that you understand that insurance policies are an arrangement between you and your insurance company. You are personally responsible for all charges incurred in this office. Please bring this completed form to your first appointment and keep a copy for yourself so that we have all the information necessary to submit your claims.

Patient Name_____

1. Does my policy have coverage for an out of network acupuncturist? Yes No
   Does my policy have coverage for an in network acupuncturist? Yes No
   If yes, specify:_____
   % of coverage _____Number of visits per year _____ Maximum $ amount per year _____
2. Does my policy have coverage for an out of network massage therapist? Yes No
   Does my policy have coverage for an in network massage therapist? Yes No
   If yes, specify:_____
   % of coverage _____Number of visits per year _____ Maximum $ amount per year _____
3. Does my policy have coverage for Manual Therapy (CPT code 97140) performed by an Acupuncturist?
   If yes, specify: _____ What benefit does it pull from _____
   % of coverage _____Number of visits per year _____ Maximum $ amount per year _____
4. Do they also include: Office visits? Yes No
5. What is my Co-Pay for acupuncture _____/ massage_____
6. What is my deductible? _____. Is the deductible yearly? Yes No
7. Has the deductible been paid for this year? Yes No
8. What is the effective date of my policy? _____
9. Do I need a referral for an out of network/ in network acupuncturist? Yes No
   If yes, from whom? _____
10. Do I need a referral for an out of network/in network massage therapist? Yes No
    If yes, from whom? _____
11. Does the plan require pre-authorizing from the insurance company? Yes No
12. What are the address and phone that the bills must be sent to?

Address: _____

_____

Phone:_____ Fax:_____

Date you called:_____ Person you spoke with:_____

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