

### Insurance Verification

As a service, we bill insurance carriers directly. Ultimately, it is the patient's responsibility to verify benefits before your first appointment and again at the beginning of each plan year. If you require a secondary insurance company billed please fill out another copy of this form for that plan.

**Name:** \_\_\_\_\_ **Insurance Co:** \_\_\_\_\_

**Member #:** \_\_\_\_\_ **Group # (if available):** \_\_\_\_\_

**Please call the customer service number on your insurance card and ask the questions below.**  
You may refer to these numbers: *Jason Moskovitz provider # 1023258209, clinic tax # 81-1829238, clinic provider # 1912369430*

<b>Is the plan currently active?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Plan renewal date:</b>
<b>Is Jason Moskovitz in network?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If out of network, will my policy cover acupuncture performed by this provider?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Is Acupuncture covered?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is a prior authorization required?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is there a copay or coinsurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Inquire about limitations on your benefits. Acupuncture may be denied for certain diagnoses.</b> <b>We can provide a diagnosis code if needed. Please ask about:</b> <input type="checkbox"/> Total visits _____ (# used _____)	
<b>Can acupuncture be received by a licensed acupuncturist?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (Some plans require MDs)	
<b>Some plans' Physical Therapy benefits may be used for these codes. Please ask about coverage, limitations, or prior authorization needs for:</b> <i>Heat (97026), Bodywork (97140).</i>	
<b>Notes:</b> _____	
<b>Call date:</b>	<b>Time:</b>
<b>Representative Name:</b>	<b>Reference #:</b>

I acknowledge that the above information is valid and correct. I understand that benefit verification is not a guarantee of insurance coverage, and that I am financially responsible for all services rendered.

\_\_\_\_\_  
**Responsible Party Signature**

\_\_\_\_\_  
**Date**