Name: _____

Insurance Verification Questionnaire

Please complete the top section and return to ZenMed Acupuncture for verification of eligibility of benefits. We will attempt to complete verification and notify you of the outcome as quickly as possible.

Today's Date: _____ Male ☐ Female ☐ DOB: ____/_____/_____

Address 1: _____ City/ State: _____

Address 2: _____ Zip: _____

Insurance Carrier: _____ Insurance Phone: _____

Member ID#: _____ Group #: _____

Employer Providing Insurance Plan: _____

Email: _____ Cell Phone: _____

(Below this line is for office use only).

In Network ☐, Out of Network ☐ Calendar Year ☐, Contract Year ☐

Provider Information/ Verification Phone#: _____

Insurance Company Representative Name: _____

Date & Time: _____ Acupuncture Coverage? Yes ☐ No ☐

Comments/ Restrictions: _____ Pre-Auth Required? Yes ☐ No ☐

If Yes, Contact: _____

Acupuncture Tx/ Year: _____ # Tx Used: _____ out of _____

Yearly Deductible: Individual $_____ Amount Met: _____ out of _____

Family $_____ Amount Met: _____ out of _____

# of Persons _____ # Claimed _____ out of _____

Does deductible apply to acupuncture? Yes ☐ No ☐ Max. Out of Pocket/Year: $_____

If the deductible is not met, do visits count toward the max visits/year? Yes ☐ No ☐

Co-pay or co-insurance for acupuncture? Copay $ _____ Co-Insurance _____

Call/Inquiry Reference #: _____

Claims billing address: _____ Phone: _____

_____ Fax: _____

_____