SELAH
NATURAL MEDICINE

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INSURANCE VERIFICATION FORM

By signing this form, I request that authorized insurance payments be made to the clinic/ provider for any services furnished me by my provider or supplier. I also authorize the release of any medical information requested about me that is necessary to determine, benefits, payable, or otherwise, for related services. I also agree to pay for any services that are not covered by my insurance company (Policy does not apply to Medicaid, Care or Family Oregon Plans).

PatientName:_____ Date of Birth:_____

Primary Insured Name:_____ Date of Birth:_____

Relationship to primary insured: ____Self ____Spouse ____ Child ____Other_____

Insurance Company:_____Insurance Phone: _____

Insurance Address: _____

Policy#:_____ Group#/Plan Name:_____
Effective Date:_____ Co-pay (if known) _____

_____ _____
Signature **Date**

********** **OFFICE USE ONLY** **********

In-Network Coverage? Y N _____Out of Network Y N _____
Deductible:_____Amount Met: _____ Effective Date:_____
OOP Max:_____OOP Met:_____Copay Amount:_____
Separate Office Visit and Physical Medicine CoPay Y N
Exclusions/Stipulations - Based on anesthesia Y N Based on condition Y N
Does patient have a Health Savings or Reimbursement (FSA) Account? Yes No
Is policy based on a calendar year or contract year? Calendar Contract
If contract year, what are the dates: _____
Number of visits per year _____ Dollar amount per year: _____
Any pre authorization for advanced imaging: **Xray** Yes No **MRI** Yes No
ACN form required? Yes No
Is there a limit on modalities when billed with a CMT code? Yes No
Is there a double copay for visits with exams or re-exams?_____
Claims address:_____
Electronic Payer ID for Provider_____
Revised 10/6/14