

Amy Jenner, L.Ac.

INSURANCE VERIFICATION

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last Name, First Name

Patient Address: \_\_\_\_\_

City, State & Zip(Must Have) \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_

Patient, Subscriber # / ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insured Name & ID# (if Different from patient) \_\_\_\_\_

Relationship to Insured: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

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

Ins. Co. Phone #: \_\_\_\_\_

Chief Complaint or Primary Diagnosis: \_\_\_\_\_

Claim # if an accident: \_\_\_\_\_

Date of Accident/ Injury: \_\_\_\_\_

Other Info: \_\_\_\_\_

To be completed by office staff: \_\_\_\_\_ Date Verified: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Spoke To: \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Amount met \$ \_\_\_\_\_

Acupuncture Yes / No # of Visits \_\_\_\_\_ % allowed \_\_\_\_\_

Any Restrictions ? Diagnosis , Provider type... \_\_\_\_\_

PT Yes / No # of Visits \_\_\_\_\_ % allowed \_\_\_\_\_

Office Visit Yes / No

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