

Acupuncture Insurance Verification

Bret J. Shulman Acupuncture
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PATIENT INFORMATION:

Name _____ M/F _____ SS# _____

Address _____ City/State/Zip _____

Tel# Home _____ Work/Cell _____ DOB _____ Marital Status: S M D DP

Main Complaint: _____ Email address: _____

PRIMARY INSURANCE INFORMATION: Relationship to insured: Self/Spouse/Child/Other (Please circle one)

Ins. Co. _____ Tel# _____

Address _____

Insured Name _____ Insured's Employer _____

Insured DOB _____ Insured SS#: _____ ID# _____ Group _____

HOW IT WORKS

We accept ANY out of network insurance coverage that recognizes acupuncture.

- Deductibles vary from plan to plan. We do not know what your insurance company will apply to your deductible until the claim is processed. Patients who only come for a few treatments will most likely not satisfy their deductible and will be responsible for our fee. Please discuss your deductible with the office staff for payment arrangements. Credit card information will be kept on file for ease of payment.
- In many cases, all documentation and reimbursement is sent to the patient. It is imperative that all documentation and payments be brought to the office and be endorsed over to us. Please bring all paperwork you receive, even if it was applied to deductible and there was no payment.
- For Medicare primary patients (with secondary policy which covers acupuncture) there's an added step. Claims will be sent to Medicare first (in many cases for denial purposes only). You will receive denials and/or partial payment from Medicare, which we need to then submit to your secondary for reimbursement. It is your responsibility to bring in all correspondence and/or payments from Medicare to our office.

By signing below, I _____, indicate that I understand my role in the procedure to have my acupuncture covered by insurance. I agree to cooperate with bringing in all documentation and payments I receive within 30 business days, and that ultimately I am responsible for payment. If I fail to cooperate with this procedure, Bret J. Shulman Acupuncture has authorization to charge my credit card the appropriate fee for services rendered.

Name _____ Date _____