# 

**Renee Schwartz, ND**

**Nathalie Paravicini, ND**

**Ron Hubbs, Lac**

**Karen Davis, MS, NTP**

**7000 SW Hampton St. Ste 130**

**Tigard, OR 97223**

**503-639-3777**

**Fax 503-639-1120**

# INSURANCE VERIFICATION

You are responsible to verify that your insurance company pays in a timely manner. Fulfilling this responsibility may require you to contact your insurance company. Your coverage is between you and your insurance company. We are glad to will help you present your claim, but you must take ultimate responsibility for your account.

Most insurance plans have determined certain services that may not be covered, such as preventive visits, immunizations or elective services. We try to inform you of the rules ahead of time, but we don’t always know if a service is covered. Since there are so many coverage plans available, you are encouraged to review your policy, contact your insurance company, and understand your benefits.

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Beginning date of coverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Call the customer service number listed on your card, select the option for benefits and eligibility or subscriber services, and ask the representative *ALL* of the following questions:

1. Do I have naturopathic coverage? YES / NO
2. If NO- can my naturopath still order my labs? YES / NO
3. If YES – do lab expenses apply to my Naturopathic Benefit Limit? YES / NO
4. Do I have acupuncture coverage? YES / NO
5. Do I need a referral from my primary care physician (PCP) for alternative services? YES / NO
6. Is my practitioner in-network or a preferred provider for my insurance plan? YES/NO  
    (Nathalie Paravicini, Ronald Hubbs, or Renee Schwartz)
7. Are my in-network and out-of-network deductibles combined? YES/NO
8. Is my deductible waived for office visits?
9. What are my benefits for the following services:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **In-network**  **COPAY**  **(% or $)** | **Out-of-network**  **(% or $)** | **Deductible**  **Amt.**  In-Net Out Net | | **Deductible**  **Remaining**  In-Net Out Net | | **# of Visits**  **Allowed** | **Max**  **$ Amt. Allowed** |
| **Naturopathic Care** |  |  |  |  |  |  |  |  |
| **Acupuncture** |  |  |  |  |  |  |  |  |
| **Nutritional Counseling** |  |  |  |  |  |  |  |  |
| **Lab Work** |  |  |  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Lab code Covered: | Yes | No | \*Please note- We use Out of Network Labs for these codes. |
| 83516 |  |  |  |
| 86001 |  |  |  |
| 86003 |  |  |  |
| 96365 |  |  | \*This is an IV code. |

Representative name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **ASSIGNMENT OF INSURANCE BENEFIT AND VERIFICATION ACKNOWLEDGMENT**

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all the services rendered to me by NW Naturopathic Medicine (NWNM) and its practitioners. I also understand that all out-of-network (non-contracted) insurance billing services provided by NWNM on my behalf are performed on a courtesy basis and can be discontinued by either myself or NWNM with written notice at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to the providers(s) at NWNM. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature of patient Print Patient Name Date

Signature of responsible party if other than patient Print Name of responsible party Date