Date:_____

Health Insurance Verification Form

Well Within, LLC NPI # 1316216229, 1053685198 EIN # 45-3416344
709 NE 5th St Gresham, Oregon 97030

Patient's Name_____ DOB_____

Patient Address_____

City, State & Zip_____

Patient Phone #_____ Ins Co Phone #_____

Insurance Company Name_____

Patient, Subscriber #/ID #_____

Group #_____ Relationship to insured_____

*Patient signature and permission to check benefits_____

- Are there acupuncture benefits?_____referral?_____
- Are the benefits in- or out-of-network?IN-_____Out-_____
- What is my provider network affiliation?_____
- **Is there a deductible?_____Been met?_____**
- Calendar year or fiscal year? Visits per year?_____ Used?_____
- Is there a dollar limit per year?_____ How much used?_____
- What other modalities draw from that limit?_____
- Set co-pay?_____ Co-insurance? (% of allowable)_____
- **Is Pre-Authorization required?_____**
- What is the timeframe for claim submissions?_____

Claim Submission address?_____

_____

Any special submission requirements?_____

_____

Representative_____ Call Reference #_____