

WBS Acup Ins Verification Form**Provider :**ZenVi

Patient Name: _____ Geder: _____

DOB: _____

Insured ID#: _____ Group#: _____

Patient Address: _____

City LA State CA Zip _____

Insured's Name: _____ Ins. Co Phone#: _____

Ins. Co. Name: _____

Ins. Co. Claims Address: _____

GENERAL INFORMATION

Date: _____

Person Spoke To: _____

Effective Date: _____

Plan Type: _____

IN / OUT of Network Benefits

CALENDAR (Jan-Dec) / ANNUAL Plan

If annual plan, from _____ to _____

DEDUCTIBLE/OUT OF POCKET INFORMATION

Individual Deduct \$ _____ Amt Met \$ _____

Family Deduct \$ _____ Amt Met \$ _____

Deduct Combined In & Out of Network YES / NO

Max out of pocket \$ _____ Amount met \$ _____

Once met claims pay at 100% YES / NO

VISIT LIMIT INFORMATION

Visit Maximum _____ Visits Remaining _____

Combined With _____

Combined In & Out of Network? YES / NO

When meeting deduct, are max # visits used? YES / NO

Annual \$ Max _____ Amt used \$ _____

PLAN PAYMENT INFORMATION

% Paid _____ OR Visit \$ Max _____

Copay _____

Payment made to Patient? YES / NO / POSSIBLY

REFERRAL INFORMATION

Need a Dr.'s referral? YES / NO

PCP: _____

Rx needed? YES / NO

Auth Required? YES / NO PH# _____

Additional Visits PH# _____

Submit clinical treatment form after _____ visit.

PROCEDURES COVERED INFORMATION

Exams Covered? YES / NO % Paid _____

Copay: _____ Non-Discrimination Law Applies YES / NO

Modalities Covered?

97140 Manual Therapy YES / NO

97010 Hot/Cold Packs YES / NO

97124 Massage Therapy YES / NO

97026 Infrared YES / NO

97016 Cupping/Moxi YES / NO

97110 Therapeutic Exercises YES / NO

NOTES: _____

The Year-to-Date information provided reflects all claims processed. Please note, however, there may be claims that are pending that are not reflected in these totals. Eligibility verification is subject to the terms of your Participation agreement. This is not a guarantee of payment, payment is based on the terms of the enrollee's benefit plan.

*****CONFIDENTIALITY NOTICE*****The documents including and/or accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.