

# Hong's Acupuncture Healthcare Center Insurance Verification

Patient Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Patient Date of Birth: \_\_\_\_\_

Patient Subscriber # / ID# (if different from patient): \_\_\_\_\_

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

Relationship to Insured:    Self                  Spouse                  Child                  Other

Patient Status:    Single                  Married                  Other

Insurance Company Name: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

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

Date of Accident: \_\_\_\_\_

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

\_\_\_\_\_

**To be completed by office staff:**

Deductibles: \$ \_\_\_\_\_                  Amount met: \$ \_\_\_\_\_

Visits per year: \_\_\_\_\_                  Allowable: % \_\_\_\_\_

Acupuncture: Yes                  No                  Units / Visits: \_\_\_\_\_

Office Visits: Yes                  No                  Units / Visits: \_\_\_\_\_