



## Insurance Information Form

**Patient's Name** (Please print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: (Male /Female)

Marital Status: \_\_\_\_\_ Employer: \_\_\_\_\_

### **Primary Insurance Information**

Insurance Company \_\_\_\_\_

Insured ID# \_\_\_\_\_

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

Your relationship to insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other (specify) \_\_\_\_\_

**Insured's:** Name: \_\_\_\_\_ Gender: ( Male / Female )

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

Marital Status \_\_\_\_\_

Employer: \_\_\_\_\_

### **Below Line For Office Use Only**

Carrier Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claims Mailing Address (if not on card): \_\_\_\_\_

**Insurance Effective Date:** \_\_\_\_\_

**Network Used:** \_\_\_\_\_

#### **Naturopathic Coverage-**

**PP:** Co-Pay or \_\_\_\_\_ % Deductible \_\_\_\_\_ **NPP:** Co-Pay or \_\_\_\_\_ % **Deductible** \_\_\_\_\_

Please specify any exclusions, referral requirements, etc. \_\_\_\_\_

#### **Acupuncture Coverage-**

**PP:** Co-Pay or \_\_\_\_\_ % Deductible \_\_\_\_\_ **NPP:** Co-pay or \_\_\_\_\_ % **Deductible** \_\_\_\_\_

Please specify any exclusions, referral requirements, etc. \_\_\_\_\_

#### **Lab Coverage-**

Covered if ordered by ND                      YES                      NO

Are there any specific conditions - such as where blood can be drawn? or where it needs to be sent?

\_\_\_\_\_

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\_\_\_\_\_

1<sup>st</sup> Call Date: \_\_\_\_\_ 2<sup>nd</sup> Call Date: \_\_\_\_\_ 3<sup>rd</sup> Call Date: \_\_\_\_\_

Talked With: \_\_\_\_\_ Talked With: \_\_\_\_\_ Talked With: \_\_\_\_\_

Your Initials: \_\_\_\_\_ Your Initials: \_\_\_\_\_ Your Initials: \_\_\_\_\_



## Secondary Insurance Coverage Information

Insurance Company \_\_\_\_\_

Insured ID# \_\_\_\_\_

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

Your relationship to insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other (specify) \_\_\_\_\_

**Insured's:** Name: \_\_\_\_\_ Gender: ( Male / Female )

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

Marital Status \_\_\_\_\_ Employer: \_\_\_\_\_

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### **Below Line For Office Use Only**

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Carrier Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claims Mailing Address (if not on card): \_\_\_\_\_

**Insurance Effective Date:** \_\_\_\_\_ **Network Used:** \_\_\_\_\_

#### **Naturopathic Physician Coverage-**

**PP:** Co-Pay or \_\_\_\_\_ % Deductible \_\_\_\_\_ **NPP:** Co-Pay or \_\_\_\_\_ % **Deductible** \_\_\_\_\_

Please specify any exceptions, referral requirements, etc. \_\_\_\_\_

#### **Acupuncture Coverage-**

**PP:** Co-Pay or \_\_\_\_\_ % Deductible \_\_\_\_\_ **NPP:** Co-pay or \_\_\_\_\_ % **Deductible** \_\_\_\_\_

Please specify any exceptions, referral requirements, etc. \_\_\_\_\_

#### **Lab Coverage-**

Covered if ordered by ND                      YES                      NO

Are there any specific conditions - such as where blood can be drawn? or where it needs to be sent?

\_\_\_\_\_

\_\_\_\_\_

1<sup>st</sup> Call Date: \_\_\_\_\_ 2<sup>nd</sup> Call Date: \_\_\_\_\_ 3<sup>rd</sup> Call Date: \_\_\_\_\_

Talked With: \_\_\_\_\_ Talked With: \_\_\_\_\_ Talked With: \_\_\_\_\_

Your Initials: \_\_\_\_\_ Your Initials: \_\_\_\_\_ Your Initials: \_\_\_\_\_