NURTURE
family health

Insurance Benefits Verification Form

N**urture Family Health requires you present your ID and Insurance Card in order to bill your insurance.** In order to ensure an efficient billing process, it is highly recommended that all patients complete this insurance verification form at least 48 hours prior to their visit. As a service, we bill most insurance carriers directly but do not bill Out of Network Benefits. It is the patient's responsibility to be aware of their insurance coverage and co-pay, as well as any deductible and maximums. You are responsible for paying for co-pays, deductibles, and any services not covered by your insurance at the time of your visit.

If your insurance changes, please present your insurance card at the next visit and submit a new Verification of Benefits form.

IF YOU HAVE A SECONDARY INSURANCE, PLEASE SUBMIT AN ADDITIONAL VERIFICATION OF BENEFITS

Patient Name_____ **Patient phone #** _____ **DOB** _____

Subscriber Name (if different) _____ **DOB** _____

Insurance Company _____ **Insurance ID#** _____ **Group #** _____

Eligibility/Claims phone # _____ **Primary Insurance [ ] Secondary Insurance [ ]**

Claims Address _____

New Insurance Verification [ ] Change of Insurance Verification [ ]

Ask with whom you are speaking. This becomes very important if there are any problems with coverage.

Time _____ **Date** _____ **Rep Name:**_____ **Reference #** _____

1. Beginning Date of Coverage_____ **Ending Date of Coverage**_____

2. Does my insurance plan follow a Fiscal or Calendar year schedule? _____

3. Do I need *a referral from my primary care physician* (PCP) for Naturopathic Services? ___Yes ___ No

4. Is Dr. Melissa Woodyard an *In-Network or a preferred provider* with my insurance? ___Yes ___No

5. What are my *benefits* for Naturopathic services?

In Network: % Covered_____**; Co-pay** _____**; Co-Insurance**_____**; Year Max $**_____

Out-of-Network: % Covered_____**; Co-pay** _____**; Co-Insurance**_____**; Year Max $**_____

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6. What is my *deductible for the year* and has any or all of it been met?

Deductible $_____ Amount of Deductible met so far $_____ Date_____

7. Do you have coverage for labs? _____Yes _____No

% Covered_____; Co-pay _____; Co-Insurance_____; Year Max $_____

Please email this form to info@nurturfamilyhealth.com or fax to 971-999-0671 prior to your first appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!

*Please be aware that this is not a guarantee of payment. If an insurance company gives you inaccurate information they may not honor the benefits that were quoted.