Please call your insurance carrier prior to your first appointment to verify coverage benefits.

Patient:_____ DOB_____
Insurance Provider_____Insurance Phone _____
Member ID_____ Group # _____
Plan effective date _____

Insurance representative name _____Call reference # _____
Naturopathic Benefits: Copay _____ Co-insurance _____
Is a referral needed for naturopathic care? _____
Is the office visit subject to deductible? _____

Deductible Amount: _____ Amount remaining: _____
Out of Pocket maximum: _____ Amount remaining: _____
Is there a visit limit for ND care: Yes / No $ _____
Is there a financial limit for ND care: Yes / No $_____

Lab coverage:
Are labs covered before, or after deductible has been met? _____
Which labs are in network with plan? _____
_____
_____
What are the lab benefits for Out of Network labs _____
_____

Are the following codes covered, and are they pre- or post-deductible?

99354 Y N Pre Post

95004 Y N Pre Post

95024 Y N Pre Post

95027 Y N Pre Post

97140 Y N Pre Post

94010 Y N Pre Post

94060 Y N Pre Post

98925 Y N Pre Post

98926 Y N Pre Post

98927 Y N Pre Post