# INSURANCE BENEFITS VERIFICATION FORM

Please allow 15 to 30 minutes for completion of this information.

Ripple is committed to providing the best care for our patients. As a service, we bill insurance carriers directly. However, patients are responsible for all charges resulting from treatment by their provider. We require patients to check benefits before their first treatment and at the start of the new year using this form and provide us with this form. If you would like us to bill a secondary insurance company, please print off and fill out an additional Insurance Benefits Verification Form for this insurance company.

**It is the patient’s responsibility to be aware of her/his benefit coverage, deductible, co-pay, and coinsurance amounts.**

**We ask that you fill out this form to the best of your knowledge.**

|  |  |
| --- | --- |
| **Your Name:** | **Date of Birth:** |

|  |
| --- |
| **Member ID Number:** |
| **Insurance Carrier Name:** |

**Please call the customer service number from the back of your ID card and ask the following questions:**

|  |  |
| --- | --- |
| Call Date: | Call Time: |

Name of Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Call Reference Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the date my coverage began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does my policy cover ACUPUNCTURE? ☐ Yes ☐ No**

**Is this provider (Jeff Olson, L.Ac.) listed as: ☐“In network” ☐ “Out of network”**

1. If “out of network,” will my policy cover services performed by this provider? ☐ Yes ☐ No
2. Will these services be applied toward my deductible? ☐ Yes ☐ No
3. Do I have a co-pay? ☐ Yes $\_\_\_\_\_\_\_\_\_\_ ☐ No
4. Is there a maximum visit or amount per year for this service? Yes \_\_\_\_\_\_\_\_\_\_ ☐ No

**Does my policy cover MASSAGE by a licensed massage therapist? ☐ Yes ☐ No**

**Is this provider (Holly Toelke, LMP) listed as: ☐“In network” ☐ “Out of network”**

1. If “out of network,” will my policy cover services performed by this provider? ☐ Yes ☐ No
2. Will these services be applied toward my deductible? ☐ Yes ☐ No
3. Do I have a co-pay? ☐ Yes $\_\_\_\_\_\_\_\_\_\_ ☐ No
4. Is there a maximum visit or amount per year for this service? Yes \_\_\_\_\_\_\_\_\_\_ ☐ No

**Is a NATUROPATHIC PHYSICIAN an allowed provider type on this plan? ☐ Yes ☐ No**

**Is this provider (Maria Russell, ND) listed as: ☐“In network” ☐ “Out of network”**

1. Is this provider listed as “In network” at **2614 E Street Washougal, WA 98671**
2. If “out of network,” will my policy cover services performed by this provider? ☐ Yes ☐ No
3. Is compounding a medical benefit? ☐ Yes ☐ No
4. Which labs are in-network per my policy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Will these services be applied toward my deductible? ☐ Yes ☐ No
6. Do I have a co-pay? ☐ Yes $\_\_\_\_\_\_\_\_\_\_ ☐ No
7. Is there a maximum visit or amount per year for this service? Yes \_\_\_\_\_\_\_\_\_\_ ☐ No

**DEDUCTIBLE**

What is my deductible? $\_\_\_\_\_\_\_\_\_\_ How much have I met to date? $\_\_\_\_\_\_\_\_\_\_

Do I have a coinsurance? ☐ Yes \_\_\_\_\_\_\_\_\_\_% ☐ No

Does I require prior Authorization for an of the above services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assignment of Insurance Verification and Benefits Acknowledgement

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Ripple.

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**Responsible Party Signature Date**