Nature Cures Clinic

Required Benefits Form for All Patients Using Insurance

Patient Name__________________________ Insurance ID#_____________________

Nature Cures Clinic is happy to bill your insurance for your visit; however, it is the patient's responsibility to be aware of her/his coverage and co-pay/co-ins, as well as any deductible, restrictions, limits and maximums. We require all patients to have contacted their insurance company to check their benefits. Verification of eligibility is not a guarantee of payment and the patient will be responsible for any outstanding balances that the insurance company does not pay.

Please follow these steps when calling to find out your benefits and eligibility.

Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions. Online benefits and insurance handbooks will not give the same information as a live representative. When in doubt, ask for a supervisor.

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1. **When did my coverage begin and when is it valid thru?**

Beginning Date of Coverage________ Ending Date of Coverage__________

Does my insurance plan follow a Fiscal or Calendar year schedule? __________

2. **Do I have alternative care benefits? ____Yes ____No**

3. **Do need a referral from my primary care provider (PCP) for alternative care benefits? ___Yes ___No**

4. **Is Nature Cures Clinic an In-Network or Out of Network provider with my insurance ___Yes ___No**

5. **What are my benefits for the following services?**

***Be sure to find out the benefits that apply to the clinic you are being seen at; there will be different benefits depending on whether the provider is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.**

Services/Procedures:

Naturopathic Office visits: % Covered______; Co-pay/ Co-Insurance_____;

Year Max $________

Acupuncture: % Covered______; Co-pay/ Co-Insurance_____; Year Max $_____ #____

Are there limits and/or restrictions for the services? If so- what are they?

Are they combined with other services?

Chiropractic: % Covered______; Co-pay/ Co-Insurance_____; Year Max $_____ #____

Are there limits and/or restrictions for the services? If so- what are they?

Are they combined with other services?

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6. Is there a Co-pay per visit or per specialty? Please circle which one.

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

Deductible $______ Amount of Deductible met so far $_______ Date___

8. What is my Out of Pocket max $________ what is met so far towards the Out of Pocket Max$__________

9. What was the name of the representative I spoke with_________________ Date___________ (if you did not get the information that you needed- it is ok to ask for a supervisor. The insurance company works for YOU)

Please bring this form with you to your appointment. 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.**

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