CALYPSO
NATURAL CLINIC

2274 SW 2ND ST. SUITE C
MCMINNVILLE OR 97128
PHONE: (503) 472-5500

INSURANCE BENEFITS VERIFICATION

(Please allow 1 hour for this form, and bring it completed to your first appointment)

PATIENT INFORMATION

Name _____

Address _____

Phone _____ Date of Birth_____

INSURED INFORMATION (IF DIFFERENT)

Name _____

Address _____

Phone _____ Company _____

Date of Birth _____ Relationship to Patient _____

INSURANCE COMPANY INFORMATION

Name _____

Phone _____

ID# _____ Group # _____

It is your responsibility to be aware of your benefits, including coverage, co-pay, deductible, and maximums. Please call the number listed on the back of your insurance card, and fill out the form below.

1. Name of Representative I am speaking with _____ Date _____

2. Beginning Date of Coverage _____ Ending Date _____

3. Does my insurance cover Naturopathic Doctors? Yes/ No

4. Is Calypso Natural Clinic a covered provider under my plan? Yes/ No

5. Are extended office visits covered? CPT Code 99354. Yes/No

6. Do I need a referral from my primary care physician to see a ND? Yes/ No

7. What is my co-pay or % covered for:
    1. Office Visits _____
    2. Lab Work _____
    3. Diagnostic Imaging _____

8. What is my yearly maximum for naturopathic office visits? _____

9. What is my yearly maximum for naturopathic lab work/diagnostic imaging? _____

10. A. Do I have an annual deductible? Yes/ No Amt. of deductible met so far _____

    B. Is my deductible based on calendar year? Other? _____

11. A. Are office visits or labs subject to my deductible? _____

    B. Is Quest a preferred lab? Yes/ No

    C. Other preferred labs?
    _____

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 any provider at Calypso Natural Clinic. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Calypso Natural Clinic. This authorization will be considered valid unless revoked by me in writing.

Signature ____ **Date**_________________________