

Colleen Gibson Acupuncture LLC

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Insurance Verification Form

Your name _____

Name of Insurance Provider _____

Insurance phone number _____

Effective date _____ ID# _____

Do you need a referral? Yes / No

If yes, name and number of referring physician is:

Are Out-Of-Network providers covered? Yes / No

If yes, are there any differences in what will or will not be covered?

of visits allowed per year _____

OR

Max \$ amount allowed per year _____

Deductible amount _____

Deductible paid to date _____

Co-Pay at time of visit _____

OR

% insurance will pay _____