

ACUPUNCTURE NORTHWEST

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INSURANCE VERIFICATION FORM

YOUR NAME _____

EFFECTIVE DATE _____

NAME OF INSURANCE _____

DO YOU NEED A REFERRAL? YES/NO

IF YES, NAME OF REFERRING PHYSICIAN IS

OF VISITS PER YEAR _____

OR

MAX \$ AMOUNT PER YEAR _____

DEDUCTIBLE AMOUNT _____

DEDUCTIBLE PAID TO DATE _____

CO-PAY _____

OR

% INSURANCE PAYS _____

