

Blue Shield Insurance Form

Patient's Name _____ Patient DOB ____/____/____

Insured Name _____ Member /SubscriberID#: _____

Group#: _____ Relation to insured: self spouse/partner child/dependent

Claims Address: _____ City/State/Zip _____

Daytime Phone: (_____) _____

In order to (1) verify your insurance coverage and (2) bill *Blue Shield*, we have to disclose personal health information. (If you do not want this information disclosed, we will not be able to bill directly. In that case, we will be happy to give you a statement for you to submit.) We will verify your health coverage with *Blue Shield* via telephone in order to determine your portion or co-pay. Please note: when your benefits are quoted, the insurance company always informs us that "telephone verification of benefits are not a guarantee of payment" and "actual payment will be determined after a bill is received". Also, please be aware that often the benefits quoted over the phone differ from what we receive after we send the insurance company your bill.

We will try our best to determine what dollar amount you are responsible for with the information provided to us by *Blue Shield* over the phone. Please keep in mind that the amount originally determined may be subject to change after we receive the first payment from *Blue Shield*. Any balance not received from *Blue Shield* within the lawful 45 days will immediately become due and payable by you. If you have not informed us of a change in your coverage or information and we have to reprocess your bill, you will be charged a reprocessing fee of \$25.00 for each bill.

By signing this, you are authorizing us to release the necessary information for payment of claims, and assigning benefits to be paid directly to our office.

Signature _____ Date _____

Office Use ONLY

Verification of Benefits:

Acupuncture: Y / N (circle) In-network Out-network

Acupuncture deductible:\$ _____ Amt. of deductible met to date \$ _____

Co-pay _____ % of contracted rate _____

Max # of visits _____ Max \$ Benefit _____ Stop/Loss (Max out of pocket) \$ _____

Limits on Chief Complaints/Diagnosis _____

NOTES: