

INSURANCE PRE-AUTHORIZATION FORM

Patient Name: \_\_\_\_\_ Birthday \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Policy Holder (if different): \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

(ON BACK OF CARD):

Insurance Company Phone ('Health Care Providers' phone number, please): \_\_\_\_\_

Insurance Company Billing Address \_\_\_\_\_

-----BELOW: STAFF USE ONLY-----

Is Acupuncture covered?    Y    N                      How many visits per year: \_\_\_\_\_

Effective date: \_\_\_\_\_                      Co-pay? \$ \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ Met?    Y    N            If NO, how much met? \$ \_\_\_\_\_

Shared benefit w. Chiro/PT/other?            Y    N

Billing Codes or Flat Allowance?    CODES    FLAT    (if flat, how much? \$ \_\_\_\_\_)

**Billing Codes / Coverage Amounts**

97810		99213	
97811		99214	
97813		97010	
97814		97124	
99203		97140	
99204		97112	
99205			
99212			