Dr. Loren Riccio, ND, LM, CPM
Dr. Ashley Skluzacek, ND, LM, RN
Dr. Michal Waldfogel, ND
Dr. Kellie Moore, ND
Dr. Erinn O'Brien, ND

Insurance Benefits Verification

Date ________________
Patient Name ____ Patient DOB _______________________
Subscriber Name ______________________________________ Subscriber DOB ___________________
Insurance Company ____________________________________ Effective Date _____________________
ID# (Including Alpha Prefix and/or Suffix) _______________________ Group #___________________
Address ______________________________ Phone # (Back of Card) ______________________________

Questions to Ask

- *Is my doctor a preferred (in network) provider?*
  Provider Name ____ Tax ID# 26-4011645
- *If they are not in network, do I have out-of-network coverage? How will my care be covered out-of-network?*
  ____
- *Is my doctor designated a primary care provider or a specialist?*
  PCP / Specialist
- *Does my plan cover naturopathic medicine or services rendered by a naturopathic physician?*
  Covered: Y/N Subject to Deductible: Y/N
- *Do I have a deductible, and how much is remaining?*
  Deductible $________________ Met $________________ Remaining $_____________________
- *Do I need a pre-authorization? Do I need a referral? Are there any limitations on the amount of visits I can have?*
  Preauthorization: Y / N Referral Required: Y / N
  # of Visits Allowed ________ # of Visits Used _______
- *At what percentage will my insurance cover my care? What is my co-insurance?*
  Coinsurance: Y/N ____% Covered by Insurance ___%
- *How much do I pay at each visit (co-pay)?*
  Copay $_____________
- *What are my preventive/annual benefits? Are my preventative/annual visits available once per calendar year or 365 days after my last annual?*
  Well Visits Covered: Y/N Subject to Deductible: Y/N Copay: Y/N $_______________
  Well Visits Allowed Annually: Calendar Year / 365+1 Days
- *What are my sick/office visit benefits?*
  Office Visits Covered: Y/N Subject to Deductible: Y/N Copay: Y/N $_______________

Verified By: Rep ___________________ Reference # _____________________________________