



Eastern Elements
Acupuncture and Massage
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www.Eastern-Elements.com

Health Insurance Verification

Return this form as soon as possible to ensure coverage. Please call our office if you have any questions regarding this form.

Policy Information:

Primary Insurance

Secondary Insurance

Patient's Name: _____ SS# _____ DOB: _____

Insurance Co: _____ Insurance Co Phone: _____

Insured's Name: _____ SS# _____ DOB: _____

Employed By: _____

Policy #: _____ Group# _____ Effective: _____

Patient's Relationship to the Insured: _____

Policy Questionnaire for Insurance Company:

Call the insurance company and ask the representative all the questions below.

Date Called: _____ Person Spoken To: _____

Does Policy Cover Acupuncture? YES NO

If yes, continue with the rest of questionnaire

Does Your Policy Cover:

Massage Therapy Herbal Supplements Home Visits

Is There a Limit to the # of Visits Allowable? YES NO

If Yes, # Visits/Year: _____

Is There a Deductible: YES NO

If Yes, How Much / Year? _____

Has the Deductible Been Met? YES NO

If No, Remainder: _____

Percentage of Bill Covered By the Policy: _____ Patient's Co-Pay: _____

Are There Additional Coverage Limits? Yes NO

If Yes, Limits: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

To Whose Attention Are the Claims To Be Sent? _____