

# Insurance Verification Sheet

## How Do I Check My Insurance Benefits?

Blossom Natural Health and Wellness will gladly bill your insurance for your visit; however, **it is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums.** Please follow steps 1-7 when calling to find out benefits and eligibility.

First, Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my coverage begin and when is it valid thru?  
Beginning Date of Coverage \_\_\_\_\_ Ending Date of Coverage \_\_\_\_\_  
Does my insurance plan follow a Fiscal or Calendar year schedule? \_\_\_\_\_
2. Do I need a referral from my primary care physician (PCP) for alternative services?  
\_\_\_Yes \_\_\_No
3. Is Dr. Meredith Distanto In-Network or a Preferred Provider with my insurance?  
\_\_\_Yes \_\_\_No
4. What are my benefits for Naturopathic services?  
Naturopathic: % Covered \_\_\_\_\_ ; Co-pay/ Co-Insurance \_\_\_\_\_; Year Max \_\_\_\_\_
5. What is my deductible for the year and has any or all of it been met?  
Deductible \$ \_\_\_\_\_ Amount of Deductible met so far \$ \_\_\_\_\_ Date \_\_\_\_\_  
Are Naturopathic services subject to this Deductible? \_\_\_Yes \_\_\_No
6. What was the name of the representative I spoke with: \_\_\_\_\_ Date \_\_\_\_\_
7. Address for Claims submission?: \_\_\_\_\_ Payer ID # \_\_\_\_\_

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!

\*Please be aware that this is not a guarantee of payment, if an insurance company provides you with inaccurate information, they may not honor the benefits that were quoted.

Patient Name _____	Date of Birth _____
Insurance ID# _____	Group or Plan ID# _____
Name of Insured (if not Patient) _____	
Date of Birth of Insured _____	Employer _____ Insured is: <input type="checkbox"/> Male <input type="checkbox"/> Female
Insured Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Partner <input type="checkbox"/> Other	
Insurance Company _____	Address _____