GREEN LEAF NATURAL MEDICINE LLC

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INSURANCE BENEFITS VERIFICATION

In order for our office to bill your insurance, this form must be completed before your appointment.

All patients with insurance must complete the insurance verification form before seeing the doctor. It is vital that this form is filled out in its entirety in order for the billing process to proceed smoothly. If your insurance changes, please present your insurance card at the next visit.

Please complete the following 2 pages in their entirety and attach a front & back copy of your insurance card.

I. This is a: New Insurance Application [ ] Change of Insurance Application [ ]

A. Patient Name ____________________

Address ____________________

City ____________________ State __________ Zip __________

Phone: Work __________ Mobile __________ Home __________

Social Security # ____________________ DOB: __________

Patient is insured as a (circle one): **primary** **dependent**

B. Primary insured's Name ***(if patient is a dependent):*** ____________________

Insured's Date of Birth _____/____/_______Relationship to patient __________

Address____________________

City ____________________ State __________ Zip __________

Phone: Work __________ Mobile__________ Home __________

C. Name of Insurance Company ____________________

Claims Address ____________________

City ____________________ State __________ Zip __________

Phone ____________________ Group or Policy #____________________

Insurance ID # ____________________

(instructions and steps on next page)

II. Follow all the steps below when calling to verify benefits and eligibility. To start, call the number on your insurance card listed for ***customer service, benefits and eligibility, or subscriber services***. Ask the representative the following questions.

1. Ask with whom you are speaking. This becomes very important if there are any problems with coverage. Name of the representative ____
Date ____________

2. Ask when your coverage began and when it ends.
Beginning Date of Coverage: _______________ Ending Date of Coverage: _________________

3. Ask if Dr. Linda Gedeon, ND is on your plan. If they say no, ask if Green Leaf Natural Medicine LLC is on your plan. ___Yes ___No

4. Ask if the doctor is _____"in network" or _____"out of network".

If the doctor and the clinic are *"out of network,"* it is important to ask whether you have "out of network" benefits to see a Naturopathic Doctor: ___Yes ___No

5.
a***) If you have "in network" ND (Naturopathic) coverage***: what is your **co-pay?** $ ___ and what percent of the office visit is covered? ____ % And what is your yearly max? $ _____
b) ***If you have "out of network" ND (Naturopathic) coverage***: what is your co-pay? $ ____ and what percent of the office visit is covered? ____ %
For in and out of network coverage, the following questions may also apply and influence your coverage:
c) Ask if you need a referral from your Primary Care Provider (PCP) ___Yes ___No

6. *For both in and out of network*, ask about your deductible. What is the amount and has any or all of it been met? **Deductible $_____________ Amount of Deductible met so far $_____________**
Date_________ Does the Deductible apply to your office visits ____Yes _____ No
What year is your deductible based on? Calendar year [ ] Fiscal year [ ]

Office Visits may be between 60-90 minutes. Ask if CPT Codes 99354 and 99355 are covered under your plan ______Yes _______No

Ask if you have **TeleHealth** insurance benefits ___Yes ___No If Yes, what is your co-pay? $ ___ and what percent of the TeleHealth appointment is covered? ____ % Does the Deductible apply to your TeleHealth appointments ____Yes _____ No

7. What are your lab benefits and preferred or contracted labs?
Lab Work _________% Covered or $_______ Co-pay Year Max ________ Preferred/ Contracted: Lab-Corp [ ] Providence [ ] Quest Diagnostics [ ] Other: ________ Deductible $_____________ Amount of Deductible met so far $_____________ Date_________ Does the Deductible apply to your lab work ____Yes _____ No

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGEMENT
I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Green Leaf Natural Medicine LLC. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Green Leaf Natural Medicine LLC. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature:
____Date:_______________
Signed by: Self [ ] Guardian/Responsible Party [ ] :