

Family Tree Medicine



How Do I Check My Insurance Benefits?

Patient Name _____ Insurance ID# _____

Family Tree Medicine will happily 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** _____
2. Do I need a *referral from my primary care physician (PCP)* for alternative services?
___ **Yes** ___ **No**
3. Is the doctor I want to see (Dr. Amanda Anderson or Dr. Jennifer Maurer) *In-Network or a preferred provider* with my insurance?
___ **Yes** ___ **No**
4. What are my *benefits* for the following services? **Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.*

Specialties:

Naturopathic: % Covered _____ ; Co-pay/ Co-Insurance _____ ; Year Max _____

Acupuncture: % Covered _____ ; Co-pay/ Co-Insurance _____ ; Year Max _____

Physical Therapy: % Covered _____ ; Co-pay/ Co-Insurance _____ ; Year Max _____

Chiropractic: % Covered _____ ; Co-pay/ Co-Insurance _____ ; Year Max _____

5. Is there a copay per **visit** or per **specialty**? Please circle which one.
6. Are my alternative claims billed to **American Specialty Health** or **American Whole Health** ?
___ **Yes** ___ **No** (If yes, please circle which one)

7. 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 any of the specialties listed above **subject to this deductible?** ____ **Yes** ____ **No**

If so, **which specialties?** _____

8. What was the *name of the representative* I spoke with _____ **Date** _____

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 gives you inaccurate information they may not honor the benefits that were quoted.