

CHA Insurance Verification Form v22

Please call your insurance company using the member phone number on the back of your card to complete these questions to verify benefits. Include the name of the insurance company representative and reference number (if they give you one) for your call in the designated spaces below.

Is Celestial Holistic Arts/ Lara Thompson,
ND NPI: 1104467778 in-network? * Yes No

What is your deductible? * _____

How much is remaining on your deductible?
* _____

What is your out-of-pocket max? * _____

How much is remaining on your out-of-
pocket max? * _____

What is the copay/co-insurance for ND
office visits (99202-99205/99212-99215)? * _____

Is a referral needed by your PCP for ND
visits? * Yes No

Is prior authorization needed for ND office
visits? * Yes No

If yes, does a prior authorization need to be
submitted by your PCP?

What is your visit limit for ND office visits?
*

Are ND office visits combined with other
benefit visit limits? * Chiropractic Acupuncture Massage
 Physical Therapy Massage

Are office visits subject to your deductible?
* Yes No

Do you have coverage for Visit Code 99417
or G2212? * Yes No

PHYSICAL MEDICINE COVERAGE

Which physical medicine CPT codes do you have coverage for? *

<input type="checkbox"/> 98925-98929	<input type="checkbox"/> 97010	<input type="checkbox"/> 97012
<input type="checkbox"/> 97014	<input type="checkbox"/> 97034	<input type="checkbox"/> 97110
<input type="checkbox"/> 97112	<input type="checkbox"/> 97124	<input type="checkbox"/> 97140

What is your visit limit for the physical medicine? *

What is the copay/co-insurance for physical medicine CPT codes?

Is there an additional copay/co-insurance for these physical medicine codes? Yes No

What is your benefit maximum for physical medicine?

How much is remaining of your physical medicine benefit?

Is a prior authorization required for any of the CPT codes you selected previously? Yes No

Are these physical medicine benefits combined with

<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Massage
<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Naturopathic	

INJECTION THERAPY COVERAGE

Do you have coverage for trigger point therapy CPT codes 20552, 20553, 96372? *

What is your visit limit for trigger point therapy codes 20552, 20553, 96372? *

What categories are trigger point injection therapy bundled with (select all that apply): *

<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Massage
<input type="checkbox"/> Naturopathic	<input type="checkbox"/> Rehabilitation	

LABS (DIAGNOSTIC)

Do you have coverage for diagnostic labs? *

<input type="checkbox"/> Yes	<input type="checkbox"/> No - Skip to next section.
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What is the copay/co-insurance for labs?

Is your lab coverage subject to your deductible?

Yes No

What labs are in-network?

LabCorp Quest Diagnostics Genova Diagnostics
 Great Plains Laboratory Diagnostic Solutions Laboratory

Are labs covered if ordered by a Naturopathic Doctor?

Yes No

What is your benefit maximum for diagnostic labs?

Name of insurance company representative

*

Reference number for your call:

If a referral or prior authorization is needed, you understand that it is your responsibility to complete this process before your scheduled visit.

I understand

I, the undersigned, certify that I (or my dependent) have insurance coverage with the listed above and assign directly to Celestial Holistic Arts/Lara Thompson all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that this information is not a guarantee of payment, and it is my responsibility to understand when I have reached my benefit maximum or need a prior authorization for upcoming visits. I understand that I am fully responsible for all balances, charges not paid by insurance, and all non-billable services, fees and supplements. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

PATIENT or RESPONSIBLE PARTY

SIGNATURE *
