Skyline Integrative Medicine

Insurance Information Form

Patient, please fill out the following: Date: ___________________________________

Patient's Name: ____ D.O.B. ___________________

Insurance Company: ____ ___________________________

Eligibility & Benefits phone #: ____________________ please circle: Primary or Secondary

Insured Name: ____ D.O.B. ___________________

ID/Number: ___________________________________ Employer/Group: _______________________

For office use only

Date: ______________ Staff: _______________________ Insurance Staff: ______________________

Coverage:	**Y/N**	**Co-pay/Percentage/In network/Of network**
Chiropractic	____	______________________________
Naturopathic	____	______________________________
Acupuncture	____	______________________________
Massage	____	______________________________

Deductible:	**Amount**	**Combined/Separate**	**Remaining**
Chiropractic	_______	______________________	__________
Naturopathic	_______	______________________	__________
Acupuncture	_______	______________________	__________
Massage	_______	______________________	__________

Limits:	**# of Visits**	**Maximum per year/month**
Chiropractic	_______	______________________
Naturopathic	_______	______________________
Acupuncture	_______	______________________
Massage	_______	______________________

Supplements: Yes or No **Orthotics: Yes or No**

Pre-Authorization needed for anything? ____

Other Notes:

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