

# 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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_