Seattle Wellness Group
3611 Woodland Park Ave N Seattle, WA 98103
Phone: (206) 826-1005 Fax: (206) 826-1289

# PATIENT INSURANCE VERIFICATION

IN NETWORK OR OUT OF NETWORK (circle)

**Date:_____**

**Insurance Company & Phone#:_____**

**ID Number:_____ Group Number: _____**

**Spoke with:_____**

**"What is my annual deductible?"**

**Deductible Amount_____ Deductible Met _____**

**"Is a pre-authorization or referral required for chiropractic, massage or acupuncture?" YES NO**

**CHIROPRACTIC:**

"How many chiropractic visits are covered each year?"

Max per year: _____ I have used:_____

"What is my portion?"

Co-Pay/Co-INS :_____

**MASSAGE:**

"How many massage therapy visits are covered each year?"

Max per year: _____ I have used:_____

"What is my portion?"

Co-Pay/Co-INS :_____

"Are any other services combined under this benefit?" _____

**ACUPUNCTURE:**

"How many acupuncture visits are covered each year?

Max per year: _____ Used:_____

Co-Pay/Co-INS :_____

Confirmation or Reference #:_____

**I have contacted my insurance carrier and have provided the above benefit information. I understand that this is a quote provided to me, and not a guarantee of payment by my insurance. I understand that I am financially responsible for all services rendered.**

Signature _____ Date_____