

Insurance Benefits Worksheet

Patient name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Insured name (if different): \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Relationship to insured: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance company (Primary): \_\_\_\_\_ ID number: \_\_\_\_\_

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

Insurance company (secondary, if applicable): \_\_\_\_\_

Insurance ID (secondary): \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance company Phone #: \_\_\_\_\_

Spoke with: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Acupuncture benefits available? Y  N

If so, by Licensed Acupuncturist. ? Y  N

Current with benefits? Y  N

Network Provider r'qd? Y  N  Is Philip Kelley in network? Y  N

Referral required? Y  N  Physician only, or DC, ARNP, etc: \_\_\_\_\_

If Related to an Auto Accident

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ ext \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Which State did the Accident Occur in? \_\_\_\_\_

Claim Number: \_\_\_\_\_

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For Office Use Only

Date: \_\_\_\_\_ Spoke With: \_\_\_\_\_

Open Claim? Y / N Date Active: \_\_\_\_\_ Benefits: \_\_\_\_\_

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Fax Claim Info to: \_\_\_\_\_