Heart Spring Health

INSURANCE BENEFITS VERIFICATION

(Please take your time. This can take anywhere from 10 to 30 minutes to complete)

In order for our office to bill your insurance, this information must be known prior your appointment. Our office does check insurance, but many times does not get as accurate of information as if the member calls his/her insurance plan themselves. If insurance coverage cannot be determined prior to the appointment, payment is due at time of service.

Dr. Angela Cortal is committed to providing the best care for her patients. As a service, In Network and Out of Network insurance carriers are billed directly. However, patients are ultimately responsible for all charges resulting from treatment provided by their physician. Any necessary paperwork for the patient to submit to their insurance will be provided upon request.

Patients are responsible for any account balances after 90 days from time of service, regardless of payment status from the insurance company. Providing correct insurance information is the responsibility of the patient. All patients must be familiar with their own insurance coverage before seeing the doctor. It is vital that this form is filled out in its entirety.

If your insurance changes, please present your insurance card prior to the next visit. It is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximum.

Please complete the following 2 pages in their entirety and show your insurance card at your first visit.

This is a: New Insurance Application □ Change of Insurance Application □

Patient Name _____ DOB: _____

Address _____City _____ State _____ Zip _____

Phone: _____

On the insurance plan, the patient is insured as a **primary** □ *or* **dependent** □

Insurance Company: _____

Subscriber I.D. #: _____ Group #:_____

Insurance phone number for Providers: _____

<u>If you are a dependent on your insurance plan</u>, please list the following information *for the primary insured*:

Name: _____ Date of Birth: _____

Gender: ___ Phone : _____ Relation to you: spouse □ parent□ other □

Same address □ *or* Street: _____ City: _____ State: _____ Zip: _____

(benefits verification instructions and steps on next page)

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Follow all the below steps when calling to verify out benefits and eligibility. To start, call the number on your insurance card listed for ***customer service, benefits and eligibility, or subscriber services***. Ask the representative the following questions.

1. Ask with whom you are speaking. This becomes very important if there are any inconsistencies later.
Name of the representative _____ Date _____

2. Ask when your coverage began and when it ends.
Beginning Date of Coverage: _____ Ending Date of Coverage: _____ Renews on: Calendar □ or _____

3. Ask if Dr. Angela Cortal, ND is In Network with your plan. ___Yes ___No
If they ask for NPIs, Dr. Cortal's is 1603128479 and Heart Spring Health (type 2 NPI) is 1043572852.

4. Ask if the doctor is _____"in network" or _____"out of network".

If the doctor and the clinic are *"out of network,"* it is important to ask whether you have *"out of network" benefits* to see a Naturopath: ___Yes ___No

5. complete *either a) or b)*
a***) If you have "in network" ND (Naturopathic) coverage***: what is your co-pay? $ ____ or co-insurance? _____ %
Is there a benefit max?_____ And what is your yearly (out of pocket) max? $ _____

b) ***If you have "out of network" ND (Naturopathic) coverage***: what is your co-pay? $ _____ or co-insurance _____ %

For out of network coverage, the following questions may also apply and influence your coverage:
c) Ask if you need a referral from a Medical Doctor/ Primary Care Provider (PCP), for Alternative healthcare services.
___Yes ___No If you would like Dr. Cortal to be your Primary Care Provider, ask whether you may do so.

d) If applicable to your care, ask if your annual physical and/or gynecological exam can be performed by an ND. ___Yes ___No can (Dr. Cortal refers annual gynecologic exams to other Heart Spring NDs and can act as a PCP by providing annual physicals and ordering labs).

6. *For both in and out of network*, ask if you have a deductible. If so, what is the amount and has any or all of it been met?
Deductible $_____ Amount of Deductible met so far $_____ Date (as of): _____
What year is my deductible based on? Calendar year [ ] Fiscal year [ ]
Do you need to meet your deductible prior to getting Naturopathic services covered? Y / N

7. Last question! What are your In Network lab benefits?
Lab Work: _____% Covered or $_____ Co-pay Any lab deductible? _____ Year Max $_____
Any restriction (such as certain lab companies you can or cannot use): _____

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGEMENT
I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Heart Spring Health. I also understand that all out-of-network (non-contracted) insurance billing services provided by Heart Spring Health on my behalf are performed on a courtesy basis and can be discontinued by either myself or Heart Spring Health, with written notice, at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Heart Spring Health. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature: _____ Date: _____