Restorative Health Clinic

6564 SE Lake Rd, Ste 100
Milwaukie, OR 97222
P: 503-747-2021 F: 503-747-2802
www.restorativehealthclinic.com

VERIFICATION OF INSURANCE BENEFITS

1.- Fill out the information as it appears on your insurance card:

Insurance Company:_____
Patient Name: _____
Patient DoB:_____
Subscriber Name: _____
Subscriber DoB:_____
Insurance ID#: _____
Group ID#_____
Insurance Phone # _____

2.- Call the number listed on your insurance card listed and ask a subscriber service representative the questions below to find out your benefits and eligibility:

1. What is the Name of the representative I spoke to:_____Date _____
2. Is the doctor I want to see In-Network or a Preferred Provider for my insurance? **YES / NO**
3. Beginning date of coverage _____. Ending date of coverage _____.
4. Do I need a referral from my primary care physician (PCP) for alternative services? **YES / NO**
5. For an In-Network doctor I have _____% coverage and/or $_____ co-pay.
6. Is the provider I want to see covered as an Out-of-Network Provider? **YES / NO**
7. For an Out-of-Network doctor I have _____% coverage and/or $_____ co-pay
8. Are any of services (office visits) subject to deductible? **YES / NO**
9. Are Labs ordered by an ND (Naturopathic Doctor) covered? **YES/NO**
10. Do I have a deductible to meet?_____
11. If so, how much of a deductible _____ and within what period of time _____

_____ (Initials) I understand that I am financially responsible for any co-pays, deductibles, services, treatments, that my insurance company do not cover.

Name: _____ Date _____