2bwell Insurance Verification Form

Date: _______________ Info received by: __________________

Patient's Name: _______________________________________ Patient DOB: _____/_____/_____
Relationship to Insured: ___ Self ___ Spouse ___ Parent / Guardian ___ Child / Dependent

Primary insurance: __________________________ID#________________Date_____________

Acupuncture:	
Is prior authorization needed	
Is there any deductable	
How much is satisfied	
Co-pay / Co-Insurance	
Yearly limit $ / Yearly TX#	
Chiropractic:	
Is prior authorization needed	
Is there any deductable	
How much is satisfied	
Co-pay / Co-Insurance	
Yearly limit $ / Yearly TX#	
Massage:	
Is prior authorization needed	
Is there any deductable	
How much is satisfied	
Co-pay / Co-Insurance	
Yearly limit $ / Yearly TX#	
Naturopathic:	
Is prior authorization needed	
Is there any deductable	
How much is satisfied	
Co-pay / Co-Insurance	
Yearly limit $ / Yearly TX#	
Labs:	
What % is covered	
Is prior authorization needed	
Contracted Facilities	
Imaging:	
What % is covered	
Is prior authorization needed	
Contracted Facilities	

** Disclaimer:*
Providing proof of insurance coverage is NOT releasing a patient from
Financial responsibilities related to care they receive at 2bwell.