

**Melinda Choy L.Ac.**  
**Elevate Wellness Center**  
**Insurance Verification Form**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ Doctor's Office: Melinda Choy, LAc

Group#: \_\_\_\_\_ Referring Dr.: \_\_\_\_\_

Ins. Co. Phone: \_\_\_\_\_ Ins. Co. Name: \_\_\_\_\_

Ins. Co. Claims Address: \_\_\_\_\_

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**For ABP Use Only**

Person Spoke To: \_\_\_\_\_ Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

In / Out of NW Benefits Plan Type: HMO, PPO, POS I, POS II, EPO, IPA \_\_\_\_\_

Indiv Deduct \$ \_\_\_\_\_ Amt Met \$ \_\_\_\_\_ Family Deduct \$ \_\_\_\_\_ Amt Met \$ \_\_\_\_\_ Cal Year Ded? \_\_\_\_\_

% Paid \_\_\_\_\_ Copay \$ \_\_\_\_\_ Visit Max \_\_\_\_\_ Visits Left \_\_\_\_\_ Visit \$ Max \_\_\_\_\_ Yrly \$ Max \_\_\_\_\_  
Visits Combined with \_\_\_\_\_

Max out of Pocket \$ \_\_\_\_\_ When meeting the yearly deductible, do visits allowed get used? Yes / No  
Amt Met \$ \_\_\_\_\_

Exams Covered?	Yes / No	Need a Dr.'s Referral?	Yes / No
	% Paid _____	Rx Needed?	Yes / No
		Auth Needed?	Yes / No
		Auth. Phone#:	_____

Other Notes: \_\_\_\_\_

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