
# Insurance Verification Form (Patient-Completed)
# Seven Dragons Integrative Medicine

Please call your insurance company prior to your appointment and complete this form. This helps patients avoid unexpected charges. Please fill out one form for each insurance company and either send it to your provider via a message in the Athena portal or bring it into your next appointment.

## Patient Information

Full Name:_____
Date of Birth:_____
Date of Call to Insurance:_____

## Clinic Information (Patient Provides to Insurance)

Clinic Name: Seven Dragons Integrative Medicine
Tax ID: 45-4371302
Seven Dragons NPI: 1699622365
Provider NPI: (Select from roster at end of this form to confirm your provider's network status)

## Claims Information

What is the address where claims should be sent? (mailing address): _____
_____

## Insurance Details

Insurance Company Name:_____
Plan Name (ask for this when calling): _____
Member ID #:_____
Group # (if any): _____
Effective date of plan: _____
Policy Holder Name (if not you): _____
Policy Holder DOB (if not you): _____

## Eligibility & Plan Basics

Is your provider in network with your plan? ☐ Yes ☐ No
Is the plan active as of the date you contacted your insurance? ☐ Yes ☐ No
Is this your primary insurance? ☐ Yes ☐ No
Do you have additional medical insurance polices? ☐ Yes ☐ No – If Yes, must complete another form for the additional insurance
*For a secondary plan to be billed, patients must provide a primary plan

## Deductible

In-network deductible: $

Deductible amount that remains as of the date of your call: $
SERVICE-SPECIFIC COVERAGE
(Ask these questions for each service type you may receive)

## Acupuncture (LAc)

Is this a covered service? ☐ Yes ☐ No
Copay: $_____
or Coinsurance: %_____
Service applies towards deductible? ☐ Yes ☐ No
Visit or dollar limit? ☐ Yes ☐ No
Visits remaining: _____
Visit limits combined with other services? ☐ Yes ☐ No
If yes, which other services? _____
Any exclusions?_____
Notes:

## Naturopathic (ND)

Is this a covered service? ☐ Yes ☐ No
Copay: $_____
or Coinsurance: %_____
Service applies towards deductible? ☐ Yes ☐ No
Visit or dollar limit? ☐ Yes ☐ No
Visits remaining: _____
Is this service covered when provided via telehealth? ☐ Yes ☐ No
Notes:

## Authorization Requirements

Referral required? ☐ Yes ☐ No
Prior authorization required? ☐ Yes ☐ No
If yes, please provide any applicable details: _____

## Call Reference

Insurance Representative Name:_____
Reference Number: _____

## Notes

## Acknowledgment

Insurance verification is not a guarantee of payment.
Patient is responsible for all non-covered services.
Signature: _____
Date: _____

PROVIDER ROSTER
Please select your provider and give their NPI number to your insurance company to confirm your provider's network status with your plan.

Cameron Komisar, ND/LAc — NPI: 1699651711
Hilary Simila, LAc — NPI: 1790825362
Rachel Peterson, ND/LAc — NPI: 1457171787
Renee Shanker, LAc — NPI: 1285206847
Stefani Hayes, ND/LAc — NPI: 1568772440
Whitney Hayes, ND/LAc — NPI: 1619209640