Checking Insurance Benefits

Bring this completed form with you to your appointment. If you have trouble getting this information please contact us.

Our office will happily bill Harvard Pilgrim or Cigna for your visit; however, it is the patient's responsibility to be aware of his/her coverage and copay, as well as any deductibles and maximums. **Please follow steps 1-7 when calling to find out benefits and eligibility.**

Patient Name: _____

Insurance Company/Plan Name: _____

Insurance ID#: _____ Group #:_____

If Primary Insured is not the patient:

Primary Insured's Name: _____

Primary Insured's Date of Birth: _____

Primary Insured's Address (if different from patient):_____

Call the number on the back of your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my coverage begin? Date:_____

Is there an end date for coverage? Date:_____

Is my plan year the same as the calendar year? If not, what is the plan year? _____

2. Do I need a **referral** from my primary care physician (PCP) for specialist services? Yes No

Who is my PCP? Name: _____

Note: If your current PCP does not match the PCP on file with your plan, referrals will not be honored by your insurance and services may not be covered.

3. What is my deductible for the year? Individual $_____ Family $_____

What amount of my deductible has been met this year? $_____

4. What are my benefits for naturopathic services?

Dr. Galbraith is a **specialist**, not a Primary Care Physician.

Covered %: _____ Copay (for **specialist**) $_____ or Co-insurance %:_____

5. Is there a yearly maximum for **specialist** services? $_____

6. Will my plan cover labs ordered by Dr. Galbraith?_____

Will my plan cover labs only if ordered by my PCP?_____

Will labs be covered if performed by an out-of-network laboratory?_____

Does my plan have a preferred lab?(circle): Quest Cheshire Med Ctr

Other: _____

7. We strongly recommend you record the date, time and representative you spoke with in the event that your insurance disputes claims.

Name of the representative you spoke with: _____

Date: _____ Time: _____

I, _____, filled out the above with the help of an insurance professional and the information is accurate to the best of my knowledge.

Signature: _____ Date: _____