How Do I Check My Insurance Benefits?

Patient Name____________________________ Insurance Name__________________________
Insurance ID #___________________________ Group #________________________________
Provider Name Stephanie Kaplan, ND at Anisha 4031 SE Hawthorne Blvd, Portland, OR 97214

In order to ensure you are aware of your benefits before your visit we recommend you go through the following procedure so you know how much your insurance may cover of your care. Dr. Kaplan provides courtesy insurance billing. Anything not covered by insurance is the responsibility of the patient and will be billed directly to the patient for the outstanding amount. It is the patient's responsibility to be aware of her/his coverage, as well as any deductible and maximums.
Please follow the steps below to find out benefits and eligibility.

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

1. Do I have Naturopathic Coverage? YES___________ NO ___________
2. Beginning date of coverage _____________ Ending date of coverage______________
3. Do I need *a referral from my primary care physician* (PCP) for alternative services?
   Yes________ NO__________

4. Is the doctor I want to see (Dr. Stephanie Kaplan) ***In-Network*** *or a preferred provider* with my insurance? YES_________ NO____________
With an in-network doctor I have ________% coverage

5. Is the doctor I want to see an **Out-of Network** Provider**?** **YES_________ NO_________**
With an out of network doctor I have _________% coverage

6. What are my *benefits* for the following services? ******Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is* ***In or Out- of-Network*** *with your insurance company and whether your plan includes Out-of-Network benefits.*

Naturopathic: % Covered_______ ;Co-pay/ Co-Insurance______; Year Max_______
Acupuncture: % Covered_______ ;Co-pay/ Co-Insurance______; Year Max_______
Physical Therapy: % Covered_______; Co-pay/ Co-Insurance______; Year Max_______
Chiropractic: % Covered_______ ;Co-pay/ Co-Insurance______; Year Max _______
Massage: % Covered_______ ;Co-pay/ Co-Insurance______; Year Max _______

7. What is my *deductible for the year* and has any or all of it been met?
Yearly deductible $__________ Amount of deductible met so far $_______ Date ________

8. Are any of the specialties listed above **subject to this deductible**? **____Yes ____No**
   If so, **which specialties**? ____

9. If Dr. Kaplan is a covered provider, will lab work and imaging she orders be covered?
Labs and Imaging: % Covered__________; Copay/Co-insurance__________; Year Max_________

What is the *name of the representative* I spoke with_________________________ **Date__________**
*Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.