lotus
acupuncture

INSURANCE COVERAGE FORM

Today's Date:	Provider: Thoa Ho

PATIENT INFORMATION

Patient's Last Name: First:		
Address:	Birth Date:	Sex: ☐F ☐M
Home phone no.:	Cell phone no.:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance: ☐ BCBS ☐ Cigna ☐ UHC ☐ Aetna
Other:

Subscriber's Name: ☐ Self	Relationship to Subscriber: ☐ Spouse ☐ Dependents	Member ID: Group #:	Co-Insurance (%): Co-Payment ($):

COVERAGE

Acupuncture: ☐Yes ☐No Number of Visits Allowed/ year:	Manual Therapy: ☐Yes ☐No Number of Visits Allowed/ year:

DEDUCTIBLE

Out of Network ☐ Deductible does not need to be met. ☐ Deductible met for out of pocket. ☐ Deductible needs to be met. Remaining/ Total:	In Network ☐ Deductible does not need to be met. ☐ Deductible met for in network. ☐ Deductible needs to be met. Remaining/ Total:

VA ONLY

Social Security Number:
Authorization Number:
Diagnostic Code:

Service Dates:

COVERAGE VIA DISCOUNT PROGRAMS

Acupuncture: ☐Yes ☐No Number of Visits Allowed/ year: Cost:	Manual Therapy: ☐Yes ☐No Number of Visits Allowed/ year: Cost:

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