

Insurance Inquiry Form

E-MAIL TO info@healingartscenter.com or FAX TO (509) 685-0358

Patient Name _____ Subscriber Name _____

Subscriber Date of Birth _____ Subscriber Social Security Number _____

Employer of Subscriber _____ Insurance Group # _____

Insurance Company _____ Phone Number _____

Contact Person _____ Date _____ Time _____

Benefit Year _____ Deductible _____ Met? _____

Contract Limit out of pocket? _____ Co-Pay? _____ Deductible? _____

Preauthorization Required? _____ Referral Required? _____

Who is Eligible to Provide Services? _____

**(M.D.; D.O.; Ph.D.; ACUPUNCTURIST; MENTAL HEALTH COUNSELOR;
MSW: LICENSED, CERTIFIED, REGISTERED, MASTERS.)**

Do you Have Mental Health Benefits? _____

Do you have Physical Therapy Benefits? _____

Massage? _____

Biofeedback (90901)? _____

Alternative Health Care Benefits (Naturopathic)

Secondary Insurance Company? _____ Phone Number? _____

Policy Number? _____ Subscriber Name? _____

Other Comments? _____

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