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WHAT IS MY ACUPUNTURE COVERAGE?

Per _____ with my insurance company

Do I have Acupuncture Benefits? ☐ **Y** ☐ **N**
Can Acupuncture be performed by a Licensed Acupuncturist on my plan? ☐ **Y** ☐ **N**
If you do not have Acupuncture benefits **OR your plan does not cover Acupuncture by a Licensed Acupuncturist**, then you do not need to ask the remaining question. You will need to pay out-of-pocket for your visit.

Is my plan: **CALENDAR YEAR** ☐ or **PLAN YEAR** ☐
What date does my benefits and accumulators reset? _____

My deductible is $_____. I have met $_____ of my deductible as of today.

ACUPUNCTURE & OFFICE VISIT BENEFITS

Does my deductible have to be met before my insurance will start paying towards my visits? ☐ **Y** ☐ **N**

Is my Acupuncture benefit combined with other services? ☐ **Y** ☐ **N**
If so, which services?: **CHIROPRACTIC** **NATUROPATHY** **PHYSICAL THERAPY** **MASSAGE THERAPY**

Do I have a copay for Acupuncture? ☐ **Y** ☐ **N** My Acupuncture copay is $_____

Do I have to pay a coinsurance (%) per Acupuncture visit? ☐ **Y** ☐ **N** My Acupuncture coinsurance is_____%

Do I have a **separate** copay for office visits/exams/re-exams? ☐ **Y** ☐ **N** My office visit copay is $_____

Do I have to pay a **separate** coinsurance (%) per office visit? ☐ **Y** ☐ **N** My office visit coinsurance is _____%

Do I have a maximum my insurance will pay for Acupuncture benefits? ☐ **Y** ☐ **N**

My calendar/plan year $ maximum or visit maximum is:_____

Is my Acupuncture coverage limited to certain diagnoses? _____

If an Acupuncturist bills the following CPT codes, are they covered by my plan?:

CPT 97110 "Therapeutic Exercises" - ☐ **Y** ☐ **N** If yes, which benefit does it fall to? ☐ **ACU** or ☐ **PT/OT**

CPT 97140 "Manual Therapy" - ☐ **Y** ☐ **N** If yes, which benefit does it fall to? ☐ **ACU** or ☐ **PT/OT**

CPT 97026 "Infrared" - ☐ **Y** ☐ **N** If yes, which benefit does it fall to? ☐ **ACU** or ☐ **PT/OT**

If any of the above CPT codes falls to your Physical Therapy (PT) benefit, please ask about the following benefit information:

PHYSICAL THERAPY

Does my deductible apply for my Physical Therapy benefit? ☐ **Y** ☐ **N**

Do I have a copay for Physical Therapy? ☐ **Y** ☐ **N** My Physical Therapy copay is $_____

Do I have to pay a coinsurance (%) per Physical Therapy visit? ☐ **Y** ☐ **N** My Physical Therapy coins is_____%

Do I have a maximum my insurance will pay for Physical Therapy benefits? ☐ **Y** ☐ **N**

My calendar/plan year $ maximum or visit maximum is:_____