Insurance Information & Checklist

Thank you for choosing Function: Massage & Acupuncture for your healthcare needs. While acupuncture treatment and its benefits continue to become more integrated into the mainstream healthcare system, insurance companies in Minnesota are not yet required to cover its cost. Generally, our clinic does not file claims with personal health insurance plans but we can provide you with copies of your invoices which should contain all the information your insurance company needs. To help you speak with your insurance company in a way that might lead to coverage, we've provided the following checklist of questions that should be asked.

Checklist

1. Does my plan cover acupuncture/manual therapy?   Y / N
2. Does my insurance cover these CPT treatment codes:
   - 97810 – proc: acupuncture   y / n
   - 97811 – acupuncture additional   y / n
   - 97140 – manual therapy/massage y / n
3. What is the annual acupuncture benefit (dollar amount or number of treatments)? ___________________
4. Does my plan cover acupuncture for the treatment of *(your condition)*? ______________________________
5. Does my plan require a referral from a Primary Care Physician (PCP)?   Y / N
6. Does my plan require pre-authorization before treatment?   Y / N
7. Does my plan require re-authorization after a specific number of treatments? Y / N
8. What is the phone number, FAX number or address that I should send reports, authorization requests and claims to? ____
9. Is there an applicable deductible amount that has yet to be met? What is that amount?

   Name of representative spoken to: ____

Other notes:
-- Our services are provided in office (location code 11).
-- We are not currently in network with any healthcare providers. Therefore, you will want to be sure that your deductible cross-applies to an out-of-network deductible.
-- Under certain circumstances we may bill your insurance directly. That decision is made on a subjective basis and requires our additional insurance detail form to be filled in its entirety. You will still need to agree to our payment agreement in the event that an insurance company is unwilling to pay out your benefit.
-- Paying for CPT procedures at the time of services is a discounted rate. Standard CPT billing rates represent our rates for payors unwilling/unable to pay at the time of service. A rate sheet can be found on our website or upon request.

** We accept and encourage HSA and FSA debit cards which can be processed at the time of service. We provide all documentation necessary to have your payment approved. In some situations, your spending account administrator may require a doctor's note/referral to approve payment for massage therapy. It is your responsibility to determine if that is the case.

It is our sincere wish that you gain as much coverage as possible. If you have any questions or concerns, please contact us at 952.417.6433 or contact@functionmn.com.

FINANCIAL POLICY AND AUTHORIZATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Financial Policy and Authorization to Bill Insurance Form.

_____ **Private Pay**

Private Pay patients are patients that do not bill insurance. **This discounted cash rate is only applied to our published fee schedule if you are paying at the time of your service.**

_____ **Insurance Billing** (Medical or Auto Insurance)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Function, LLC will submit my claim for me to my insurance company. Although Function, LLC verifies my insurance; **I understand that this verification is not a guarantee of payment.** I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. **I understand that if these patient portions due are not paid at the time of service or if any benefit is not ultimately paid by my healthcare provider, I will be billed and accountable for the amount specified for services paid in arrears on our fee schedule.**

I authorize my insurance benefits to be paid directly to Function, LLC. I also authorize my provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

____ ____________________________

Signature of Responsible Party (Patient) Date

____

Printed Name

INSURANCE VERIFICATION

Date: ____________________________

Patient Name: ____

Patient Address: ____

City, State & Zip: ____________________________________ Patient Phone #: ______________________

Patient Date of Birth: __________ / ___________ / ____________ Male: ______ Female: ________

Patient, Subscriber # / ID #: ____

Group #: ___________________ Insured Name & ID# (if different) ________________________________

Relationship to Insured: Self _______ Spouse _______ Child ________ Other ________

Insurance Co Name: ____

Ins. Co. Phone #: ____

Chief Complaint or Primary Diagnosis: ____

Claim # if an accident: ____

Date of Accident / Injury ____

Other Info: ____

To be completed by office staff: Date Verified: __________________________

Effective Date: ___________________________ Spoke to: _______________________________________

Deductible $ ____________________________ Amount met $ _________________________________

Acupuncture (97810 / 97811) Yes / No # of visits ____________ % Allowed _______________

Any Additional: Diagnosis/Provider type? ____

Manual Therapy (97140) Yes / No # of visits ____________ % Allowed __________________

Office Visit Yes / No ICD9 ______________ ______________ _______________

Insurance Company Address: ____

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Other Notes: ____

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