Portland Family Health

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Portland, Oregon 97202

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Insurance Information

Patient Name: _____ Date of Birth: _____

ID #: _____ Group or Plan#: _____

Insurance Company: _____ Ins Phone #: _____

Primary Subscriber (if not Patient): _____ DOB of Insured: _____

Insured Relationship to Patient: _____ Insured is: ☐ Male ☐ Female

Please call your insurance company to obtain *all* of the following information

1. Does your plan have benefits for: Notes

Chiropractic? ☐ Yes ☐ No _____
Massage? ☐ Yes ☐ No _____
Acupuncture? ☐ Yes ☐ No _____
Naturopathic? ☐ Yes ☐ No _____
Counseling? ☐ Yes ☐ No _____

	In- Network Benefits	Out-of Network Benefits
Deductible Amount met so far		
Co-pay/ Co-insurance amount		
% Covered		
Maximum coverage $ amount $ met so far		
Maximum # visits per year # met so far		

If there is ANY coverage for massage: Notes

2. Can it be performed by an LMT? ☐ Yes ☐ No _____
3. Will these CPT codes be covered when billed up to 4 units?

97124 ☐ Yes ☐ No _____
97140 ☐ Yes ☐ No _____
97112 ☐ Yes ☐ No _____
97110 ☐ Yes ☐ No _____

4. Date of annual plan renewal: _____ *Thank You for taking the time to do this, it really helps us!*