How to Check On Insurance Coverage for Naturopathic Medicine

For those with insurance coverage other than Cigna or Harvard Pilgrim plans, I am considered an “out of network provider” and the following information you collect before our visit will assist me in providing you with an appropriately coded bill that you can then use to get reimbursed from your insurance.

Before you call your insurance provider, please have the following information ready to help your representative:

1. Insured's name and identification number.
2. Insured patient's name, birth date, address and phone number.
3. Proposed date and reason for service and/or treatment.
4. Diagnosis and/or procedure codes for the requested services. (please see #6 below for the most commonly used codes in my practice)
5. My name: Cora Rivard,N.D.,practice name: Seasons Natural Healthcare,LLC,phone number: 603-736-7770, address: 43B Birch Street, Suite #3G Derry, NH

Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my *coverage begin and when is it valid through*?
Beginning Date of Coverage _____ Ending Date of Coverage _____

2. Do I need *a referral from my primary care physician* (PCP) for alternative services?
___ Yes ___ No

3. What are my benefits, if any, for the following services?

Naturopathic: % Covered____ Co-pay/ Co-Insurance____ Year Max____

4. Are my alternative claims billed to American Specialty Health?
___ yes ___no. If yes, please circle which one.

5. What is my deductible for the year and has any or all of it been met?
Deductible $_____ Amount of Deductible met so far $_____ Date _____

6. Under my plan, may I see an **out of network physician** for any of the following services: Please record the reimbursement rate for each listed CPT code, or simply check the service if cost unknown but reimbursement is typically offered:

97802,97803:_____nutritional counseling
99401:_____risk reduction counseling

86160,86001(circle one or both): _____food sensitivity lab testing x100

99202:_____average new patient consult
99203:_____average return patient consult

7. Finally, ask if a pre-authorization for services is required. If so, please ask to be connected to the correct representative and make the request at least 48 hours prior to your appointment.

8. What was the *name of the representative(s)* I spoke with: _____ Date_____

* Please bring this form with you to your appointment. Thank you for your assistance!