



## Starfire Herbs & Acupuncture

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### HOW DO I CHECK MY INSURANCE BENEFITS?

Name \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Starfire Herbs & Acupuncture Clinic is happy to bill your insurance for your visit.  
**However, it is your responsibility to be aware of your coverage, co-pay amount / co-insurance percentage, any deductibles, or maximum allowed visits.**

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

1. When did my coverage begin and when does it expire?  
Beginning Date of Coverage \_\_\_\_\_ Ending Date of Coverage \_\_\_\_\_

2. Do I have out-of-network benefits? (Can I see a provider who is out-of-network?) ☐ Y ☐ N

3. Do I need a referral from my primary care physician (PCP) for Acupuncture services? ☐ Y ☐ N  
**If so, what are the limits with a referral / authorization? \_\_\_\_\_ visits per year**

4. Is the practitioner I want to see ( Laurie Solomon ) in-network with my insurance plan ? ☐ Y ☐ N  
If not, does my plan cover out-of-network providers? ☐ Y ☐ N

5. What are my benefits for the following services?  
**Acupuncture in-network: % Covered \_\_\_\_\_ , Copay / Co-Insurance \_\_\_\_\_**

**Annual Maximum dollar amount OR visit limit: \$ \_\_\_\_\_ / \_\_\_\_\_ visits per year**

**Are the maximum amounts combined with OTHER alternative care services ? ☐ Y ☐ N**

**If yes, which other services are combined within these limits:**

☐ CHIROPRACTIC, ☐ NATUROPATHIC, ☐ MASSAGE, ☐ PHYSICAL / OCCUPATIONAL THERAPY

**Acupuncture out-of-network: % Covered \_\_\_\_\_ , Copay / Co-Insurance \_\_\_\_\_**

**Annual Maximum dollar amount OR visit limit: \$ \_\_\_\_\_ / \_\_\_\_\_ visits per year**

6. Are Acupuncture services subject to my Deductible / Does my Deductible apply to my Acupuncture coverage?

7. What is my deductible for the year and has any of all of it been met?

**Deductible \$ \_\_\_\_\_ Amount of Deductible met so far \$ \_\_\_\_\_ on today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

8. Name of the Customer Service Representative I spoke with: \_\_\_\_\_ Date: \_\_\_\_\_

Call Reference Number (\*Required Info) \_\_\_\_\_

**If you have trouble getting the information you need, please feel free to call the clinic for assistance, and / or text the picture of both sides of your insurance card to (360) 904-3113, along with your date of birth.**

**\*\*\* Please be aware that this is not a guarantee of payment; If an insurance company gives you inaccurate information, they may not honor the benefits that were quoted. \*\*\*\***