Canyon Medical Center

2100 SW Camelot Ct
Portland, OR 97225
P: (503) 252-8125
F: (503) 256-8422

VERIFICATION OF BENEFITS FORM

The Canyon Medical Center Billing Department requires you present your ID and Insurance Card in order to bill your insurance. In order to ensure an efficient billing process, it is highly recommended that all patients complete this insurance verification form before seeing the doctor. To avoid our 48-hour cancelation fee, we strongly encourage you to inquire about your benefits. As a service, we bill most insurance carriers directly but do not bill Out of Network Benefits. Providing correct insurance information is the responsibility of the patient and therefore, patients are ultimately responsible for all charges resulting from treatment provided by their physician.
If your insurance changes, please present your insurance card at the next visit and submit a new Verification of Benefits form.

Please allow at least 1 hour for completing this form

IF YOU HAVE A SECONDARY INSURANCE, PLEASE SUBMIT AN ADDITIONAL VERIFICATION OF BENEFITS

Ask with whom you are speaking. This becomes very important if there are any problems with coverage.

Time:_____ Date:_____ Rep Name:_____ Reference #: _____

Patient Name: _____ DOB: _____/_____/_____

Subscriber/Primary Name: _____ DOB: _____/_____/_____

This is a: New Insurance Verification [ ] Change of Insurance Verification [ ]

Name of Insurance Company _____

Claims Address _____

City _____ State _____ Zip _____ Phone _____

Insurance ID # _____ Group or Policy # _____

Primary Insurance ☐ Secondary Insurance ☐ Effective Date: _____/_____/_____ Plan Year: _____ or Calendar Year

DISCLAIMER: Only certain providers at Canyon Medical Center are credentialed with Care Oregon and Open Card

If OHP, which Plan: Care Oregon ☐ Open Card ☐ **OTHER** (NOT COVERED) ☐ _____

Ask if a naturopathic doctor is considered a primary care provider (PCP) on your plan. This is important. ND's are licensed primary care providers in the state of Oregon, however some insurance companies may not cover them as primary care providers (PCPs).
If ___Yes, indicate In-Network provider(s) / Clinic Below
If ___No, is the doctor considered a specialist or part of an alternative care benefit ___Yes ___No
Specialist Copay: $_____ Co Insurance _____/_____ Alt. Care Benefit Amount: $ _____

Ask if your naturopath can perform your annual physical / wellness exam ___Yes ___No
If applicable, ask if your insurance covers gynecological care by a naturopath ___Yes ___No

Ask if the doctor you want to see is on your plan (in-network). If not, ask if NCFC LLC DBA CANYON MEDICAL CENTER is on your plan.
Provider(s) / Clinic in Network (check all that apply) ☐ **NCFC LLC DBA CANYON MEDICAL CENTER** 1295088847
☐ **Dr. Stephanie Auerbach, ND** 1295088847 ☐ **Dr. Rita Bettenburg, ND** 1881675718 ☐ **Dr. Seth Burrell, ND** 1235481995
☐ **Dr. Karen DeWitt, ND** 1316217342 ☐ **Dr. Nadia English-Williams, ND** 1497119614 ☐ **Dr. Leslie Hamlett, ND** 1073865739 ☐ **Dr. Vanessa Lyon, ND** 1366740482 ☐ **Dr. Michael Todd Pendell, ND** 1447655535 ☐ **Katerina Pozzi- Baratta, LAc** 1982063814

PT: _____

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DEDUCTIBLE

Deductible: $_____ Met: $_____

Does deductible apply to (circle all that apply) **Naturopathic** / **Chiropractic** / **Acupuncture** / **Massage** / **IV Therapy**

COPAY / CO-INSURANCE

Naturopathic Coverage Yes or No Copay:_____ Co Insurance _____/_____

Chiropractic Coverage Yes or No Copay:_____ Co Insurance _____/_____

Acupuncture Coverage Yes or No Copay:_____ Co Insurance _____/_____

Massage Coverage Yes or No Copay:_____ Co Insurance _____/_____

COVERED IF ORDERED

Circle all that apply, if ordered by:

Naturopath Lab / Diagnostic Testing / Imaging / IV Therapy*

Whereas **this is not a complete list of codes that may be used for treatment and/or guarantee of coverage by your insurance plan, you can attempt to find out if your plan will cover IV Therapy. PLEASE INDICATE IF THERE ARE ANY APPLICABLE RESTRICTIONS*

CPT codes that ***may*** be used for IV Therapy: 96372, 96365, 96374, 96366, 96367, 96375, J3420

IV Therapy Benefits Copay: $_____ Co Insurance _____/_____ ADDITIONAL CODES / NOTES: _____

VISIT LIMITS, MAXIMUMS & COMBINED BENEFITS

Ask if you have a visit limit, $ maximum allowed, and if your maximum allowed is a combined benefit for the following services.

Chiropractic Visit Limits or Dollar Maximum Yes or No **Is this a Combined Benefit** Yes or No

If yes: # of Visits or $_____ USED: $_____

Acupuncture Visit Limits or Dollar Maximum Yes or No **Is this a Combined Benefit** Yes or No

If yes: # of Visits or $_____ USED: $_____

Massage Visit Limits or Dollar Maximum Yes or No **Is this a Combined Benefit** Yes or No

If yes: # of Visits or $_____ USED: $_____

PRIOR AUTHORIZATIONS & REFERRALS (circle all that apply)

Ask if you need a referral from a medical doctor (MD)/primary care provider (PCP), for the following services.

PLEASE NOTE: prior authorizations may take some time for approval. If we have not received a formal request for and processed a prior authorization or referral, you will be required to pay at Time of Service for treatment received.

- ☐ Naturopathic Prior Authorization Required / Referrals Required
- ☐ Acupuncture Prior Authorization Required / Referrals Required
- ☐ Massage Prior Authorization Required / Referrals Required
- ☐ Chiropractic Prior Authorization Required / Referrals Required
- ☐ Physical Therapy Prior Authorization Required / Referrals Required

If you have questions/concerns, please call our Billing Specialist 503-252-8125 x4106
or email billing@canyonmedcenter.com

Statement of Financial Responsibility

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGEMENT I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is **not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Canyon Medical Center (CMC).** I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to CMC. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

_____

Sign Patient (18 years or older) Date

_____

Sign Parent, Guardian, Responsible Party Date Date

PT: _____