Amber Wellness Group (9/16)
1944 NE 45th Ave
Portland, OR 97213
Phone: 971.319.0045
Fax: 503.296.5712

Know before you go: Please verify benefits first and avoid surprises. Insurance companies can make changes at anytime without notifying members or providers.

Full payment is due at time of service. We do provide a 20% discount, for those without insurance or who choose not file an insurance claim and pay out of pocket.

Please note that you and/or your insurance company may be billed multiple procedure codes for a visit.

Name______________________________Insurance Company__________________________

Date Called__________________ Representative's Name______________________________

1. Call the member services phone number on your insurance card and ask for a customer service
representative (*automated services do not provide complete information)

2. Have your ID # and Group # available (these are on the front of your insurance card)

3. State "I am calling about my Naturopathic, Acupuncture, Massage and/or Chiropractic benefits".

4. What is my insurance effective date?____________ Calendar year?________________

5. Is my Naturopathic Primary Care Physician (ND) Dr Lisa Dickinson and/or Dr Amy Kelchner) in-network? Yes/No or out-of network? Yes/No

6. Is my Acupunturist (LAC) in-network? Yes/No or out-of network? Yes/No

7. Is my Massage Therapist (LMT) in-network? Yes/No or out-of network? Yes/No

8. Is my Chiropractor (DC) in-network? Yes/No or out-of network? Yes/No

9. Are the above complementary care modality benefits combined in-network? Yes/No

10. Are the above complementary care modality benefits combined out-of-network? Yes/No

11. Has my deductible been met? Yes/No
    How much has been met?_________________How much is left?__________________

12. What is my in-network deductible?
    ND___________LAC___________LMT___________DC___________PT____________

13. What is my out-of network deductible?
    ND___________LAC___________LMT___________DC___________PT____________

14. What is my co-pay/co-insurance?
    ND office visit___________LAC_________LMT______DC_________PT___________

15. Is there a max dollar amount covered for Naturopathic/Alternative Care for the year?
    ND___________LAC___________LMT___________DC___________PT____________

16. What is the max number of visits covered for Naturopathic/Alternative Care for the year?
    ND___________LAC___________LMT___________DC___________PT____________

17. Is my Physical Therapy (CPT code 97140) covered?
    Do I need pre-authorization? Yes/No What is co-pay/co-insurance?_____________
    Deductible?____________ Max # visits?____________ Max for yr?______________

18. Is my Osteopathic Manipulative Treatment (CPT codes 98925, 98926, 98927, 98928, 98929) covered? Yes/No
    Do I need pre-authorization? Yes/No What is co-pay/co-insurance?_____________
    Deductible?____________ Max # visits?____________ Max for yr?______________

19. Is my Massage (CPT code 97124) covered? Yes/No
    Do I need pre-authorization? Yes/No What is co-pay/co-insurance?_____________
    Deductible?____________ Max # visits?____________ Max for yr?______________

20. Is my Annual Exam (CPT code 99385/99395) covered? Yes/No
    Do I have a co-pay? Yes/No What is my co-pay/co-insurance?_________________

21. Are contraceptives covered? Yes/No

22. Is an IUD covered? Yes/No

23. Can my Naturopathic Primary Care Physician perform my IUD procedure? Yes/No

24. Can my Naturopath, licensed as a primary care provider in Oregon, order lab, imaging and diagnostic tests? Yes/No
    Are there restrictions? Yes/No If so, what are they?____________________________

25. Does my deductible go towards lab/imaging tests? Yes/No Is there a co-pay? Yes/No
    Is my deductible different for office visits, lab/imaging tests? Yes/No
    If so, how much for each?____

26. What is the patient responsibility for out-network lab/imaging tests?_________________
    Pre-deductible being met?____
    Post-deductible being met?____
    Do I need pre-authorization? Yes/No If so, for which ICD-10 codes?________________

27. What is the patient responsibility for in-network lab/imaging tests?
    Pre-deductible being met?____
    Post-deductible being met?____
    Do I need pre-authorization? Yes/No If so, for which ICD-10 codes?________________

28. Is there a preferred network lab? Yes/No (please circle below)
    Legacy Providence Quest OHSU Other______________________________

29. Is there a preferred network for imaging? Yes/No (please circle)
    Legacy Providence Epic OHSU Other________________________________

I understand that it is my sole responsibility to call my insurance company and find out what my plan coverage is. I also understand that I am responsible for all charges not covered by my insurance company that I request or that are recommended to me by my doctor.

Name____

Signature____

Date____

AWG Respresentative___________________________Date Received______________________

Amber Wellness Group is not liable for unexpected fees I may incur during my treatment in the clinic.