

Amber Wellness Group (12/16)

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? Yes/No
Do I need pre-authorization? Yes/No What is co-pay/co-insurance? _____
Deductible? _____ Max # visits? _____ Max for yr? _____
18. Is my Acupuncture (CPT codes 97810, 97811, 97813, 97814, 97026) 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 Therapy (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 Extended Time (CPT code 99354) covered? Yes/No
What is co-pay/co-insurance? _____
21. 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? _____
22. Are contraceptives covered? Yes/No
23. Is an IUD covered? Yes/No
24. Can my Naturopathic Primary Care Physician perform my IUD procedure? Yes/No

25. 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? _____
26. 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? _____
27. 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? _____
28. 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? _____
29. Is there a preferred network lab? Yes/No (please circle below)
Legacy Providence Quest OHSU Other _____
30. 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 _____

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