**Amber Wellness Group**

**1944 NE 45th Ave; Portland, OR 97213**
**Phone: 971.319.0045  Fax:  503.296.5712**

We want you to feel empowered and understand your insurance benefits. This will help you to best manage your healthcare coverage and to avoid any unforeseen surprises. Remember: Insurance companies can make changes at any time 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 to 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_____

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

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

2. State: "I am calling about my Naturopathic Physician (ND) Primary Care Benefits for In and out of network providers.  What can you tell me about my in and out of network benefits as it relates to:
    a. Dr. Lisa Dickinson: In / Out of network
    b. Dr. Meghan Bennett: In / Out of network

3. You can also ask about your Acupuncture, Massage and/or Chiropractic benefits while you are on the phone with them, using the same language above.

4. What is my insurance effective date?_____ Calendar year?_____

5. Has my deductible been met? Yes/No How much has been met?_____ How much is left?_____. How does the deductible work with my office visits?

6. What is my co-pay/co-insurance? ND office visit_____

7. Is there a maximum dollar amount or maximum number of visits covered for Naturopathic/Alternative Care for the year? No / Yes: $ / # _____

8. Is Physical Therapy (CPT code 97140) covered? Yes/No
   Do I need pre-authorization? Yes/No

9. Does my insurance cover the following codes? G2212 Yes/No 99417 Yes/No These codes allow my provider to bill for the time it takes to review chart notes and labs, prepare for my visit as well as develop a treatment plan and provide me with all the care required to complete my visit.

10. Does my plan support telemedicine visits? Yes / No Is there a date when telemedicine will no longer be covered? If so, when _____

11. Does my plan cover communicating with my provider via portal messaging/ e-consult (CPT code 99421-99423)? Yes / No

12. Is my provider able to do my Annual Exam (CPT code 99385 or 99395 covered)? Yes/No Do I have a co-pay for my annual exam? Yes/No

13. Does my insurance plan cover Vitamin D testing for codes R53.83 (fatigue) or F33.0 (mild depression)? Yes / No (These are common diagnosis codes, you may not have these concerns, it is helpful to understand if the insurance company will cover vitamin D testing for anything other than M81.0 (osteoporosis)).

14. Can my Naturopath physician, 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?_____

15. Is my deductible different for office visits versus lab/imaging tests? Yes/No
    If yes, how much is the deductible for labs/imaging?_____

16. What is my responsibility for in-network lab and imaging tests?
    Pre-deductible: _____& Post-deductible: _____
    Which imaging studies do I need pre-authorization for? _____

17. Is there a preferred network lab? Yes/No (please circle)
    Legacy Providence Quest OHSU Labcorp Other_____

18. 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 prior to my first visit and every year when I receive my new insurance card. I also understand that I am responsible, and Amber Wellness Group is not liable for unexpected fees I may incur during my treatment in the clinic that are not covered by my insurance company. I will talk with my doctor to understand how the recommended diagnostic and treatment options will help us better understand my condition so that I may reach my health care goals.

Name_____

Signature_____

Date_____