ASSIGNMENT AND INSTRUCTION FOR
DIRECT PAYMENT TO DOCTOR

Patient Name:_____

Insurance Company:_____

I hereby instruct the above named insurance company to pay by check made out to and mailed directly to:

SpiritSpring acupuncture & herbs
POB 493
710 Main Street
Clayton, NM 88415

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy or by a 3rd party payor who would otherwise pay me directly, as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AND/OR CLAIM.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by the insurance policy.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or Attorney for the purpose of securing payment under this policy of insurance.

Date:_____

Signature of Policy Holder or Claimant:_____

INSURANCE WORKSHEET

Insurance Co ____**phone** ____

Person Spoken to ____

Cover acupuncture by DOM/LAc vs MD? Y N

Prior approval needed? N Y Prior Approval # ______________________________

ICD9 for prior approval request __________________ CPT codes for prior approval request _________________________

How many visits per calendar year? _______________ Dollar Amount per benefit year? ______________________________

Are visits shared with other "alternative health care providers"? Y N

What is the deductible ______________ Has Deductible been met? Y N

When is the rollover date? _____________________

What is the co-pay? ___________________________

FOLLOW-UP CALL
DATE: ________________ CLAIM # _______________ PERSON SPOKEN TO ____
ISSUE: ____
ACTION NEEDED: ____

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ACTION NEEDED: ____

Billing History example

Visit Date	Charge By	Copay	Deductible		Claim Filed		Claim #	Payment & Date Received from	
		20%	$500		Date	Amount	D= disability P= personal	Patient	Insurance
5/4/12	$50.00 LK		$400					$50.00 5/4/12	
5/11/12	$50.00		$100					$50.00 5/11/12	
5/17/12	$50.00		0	met				$50.00 5/17/12	
5/24/12	$60.00	$12.00		met	5/24/12	$48.00	1111111111	$12.00 5/24/12	$ 48.00 6/24/12
6/1/12	$60.00			n/a	6/1/12	$60.00	P000000000		$60.00 7/1/12