DR. HILARY COSTELLO
HOLISTIC DERMATOLOGY ✵ NATUROPATHIC MEDICINE ✵ SKIN SURGERY

Required Benefits Form for All Patients Using Insurance

please complete this form before your first visit

Patient Name:_____ Date of Birth :___/___/_____
Insurance Provider _____ ID# _____ Group # _____
Name of Primary: _____ Spouse / Parent / Other

Dr. Hilary Costello will submit your bill to your insurance provider for your office visit; however, **it is the patient's responsibility** to be aware of her / his coverage and co-pay, as well as any deductible and maximums.

Please follow steps 1-9 when calling to find out benefits and eligibility. Asking the following questions should help to make your call quick and efficient. Please contact our office with any questions in regard to this process.

First, **Call the number** on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions. Online benefits and insurance handbooks will not give the same information as a live representative.

1. When did my *coverage begin and when is it valid until*?
Beginning Date of Coverage _____ **Ending Date of Coverage**_____
Does my insurance plan follow a **Fiscal** or **Calendar** year schedule?_____

2. Do I need a *referral from my primary care provider* (PCP) for alternative services?
___Yes **___No**

3. Is the doctor Hilary Costello ***In-Network*** *or a* ***preferred provider*** with my insurance?
___Yes **___No**

4. What are my ***benefits*** for the following services? * *Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.*

Specialties & Procedures:

Naturopathic: % Covered _____;Co-pay/ Co-Insurance_____; Year Max_____

Minor Surgery % Covered_____ ;Co-pay/ Co-Insurance_____; Year Max_____

Labs/Imaging % Covered _____ when billed to an In-Network Lab.

For referral purposes:

Acupuncture: % Covered _____;Co-pay/ Co-Insurance_____; Year Max_____

Physical Therapy: % Covered _____;Co-pay/ Co-Insurance _____; Year Max_____

Chiropractic: % Covered _____;Co-pay/ Co-Insurance _____; Year Max _____

5. Is My **Annual Gynecological Exam Covered by a Naturopathic Physician?** _____

If so, what is the coverage? _____

6. Is there a **Co-pay** per **visit** or per **specialty**? Please circle which one. Amount? $_____

7. What is my ***deductible for the year*** and has any or all of it been met?

Deductible $_____ Amount of Deductible met so far $_____ Date _____

8. Are any of the specialties listed above subject to this deductible? ___ Yes ___ No

If so, which specialties? _____

9. What was the ***name of the representative*** I spoke with _____ **Date** _____

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the office for assistance.

* Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information it may not honor the benefits that were quoted.

* If Dr. Costello is not a contracted In Network or Preferred Provider for your insurance company, we will collect payment at the time of the visit, and we will supply you with the proper documentation to submit to your insurance company to apply for any reimbursement you may be entitled to.

Thank you!