Dr. Yan Hong Meng, A.P.

Insurance Verification

Patient Name:_____

Patient Home Address:_____

(Must include Zip Code)_____

Patient Phone #:_____

Patient Date of Birth:_____ Male:_____ Female:_____

Patient Subscriber # / ID#:_____

Group #:_____

Patient Status: Single_____ Married_____ Other_____

Insurance Co Name:_____

Ins. Co. Phone #:_____

Claim # if an accident:_____

Date of Accident / Injury:_____

Other Info:_____

To Be Completed by Billing Office Staff:
Deductibles $: _____ Amount met $ _____ OOP:_____ Start Date:_____

AP: Y/N Restricted by MD? Y/N Visits :_____ Visits Met:____ Coverage:_____
Low back code: 724.2 Y/N

Limitations:_____
_____
_____

Office Visit (99203): Y/N Visits :_____ Visits Met:____ Coverage:_____

Manual Therapy (97140): Y/N Visits: _____ Visits Met:____ Coverage:_____

Limitations:_____
_____
_____

Specifically performed by chiropractor or PT?_____

Are acupuncture and MT combined? Y/N