CLIENT INSURANCE CLARIFICATION OF BENEFITS FORM

I am committed to providing you with the best possible care. If you have medical insurance, I am eager to help you receive your maximum allowable benefits. To achieve these goals, your assistance is needed.

Please contact your insurance company **prior to the initial appointment** to determine whether your plan has benefits to cover nutritional counseling, or if a referral or pre-authorization is required. The phone number is listed on the back of your insurance card. **Ask for a call reference number for your records and the form below.** This may help us if any issues arise in the future.

Client Name:_____ DOB:_____

Primary Insurance Carrier: _____
Call Reference Number:_____

Do I have benefits for nutritional counseling CPT codes (97802 or 97803)? □Yes □No
If yes, does the benefit cover diagnosis code Z71.3? □Yes □No
If yes, does the benefit cover diagnosis code F50.89, OSFED? □Yes □No
If yes, does the benefit have restricted diagnosis coverage? □Yes □No
If yes, what conditions are excluded from this coverage? _____

Do I have a co-pay for each visit? □Yes □No If yes, amount? _____
Do I have a deductible? □Yes □No If yes, amount of deductible $ _____
Have I met my deductible? □Yes □No If no, how much is left?

Do I have a restricted number of visits per year for nutritional counseling?
□Yes □No If yes, # of visits: _____
When is the start of your insurance calendar year: _____

Does nutritional counseling require a referral or a written order from my primary care provider?
□Yes □No If yes, please contact your primary care provider for a referral.

Does nutritional counseling require pre-authorization prior to my visit?
□Yes □No If yes, please notify Sophia Tasler, RDN, CD and request a pre-authorization from your insurance.

Is Sophia Tasler, RDN, CD in-network as a preferred provider? □Yes □No
Please note Sophia Tasler, RDN, CD has opted out of Medicare and Medcaid.

Do I have out of network benefits? □Yes □No
Do I synchronous virtual health benefits? □Yes □No

****Thank you for assisting Sage Wisdom Nutrition in clarifying your nutritional counseling benefits. It is important that you complete this form and any required referrals/pre-authorizations prior to your first visit. You are ultimately responsible for payment of services provided.****

Patient/Responsible Party Signature

Name Printed _____
Signature _____
Date _____