

Subscriber Name: _____
Insurance Company: _____
Insurance ID#: _____
Group ID#: _____

**Provider Information:**

\_\_\_\_ Stephanie Culver, ND    \_\_\_\_ Maeghan Culver, ND  
NPI#: 107-39-161-85    NPI#: 156-88-995-08

\_\_\_\_ Onyria Gillmor, ND    \_\_\_\_ Chelsey Jameson, ND  
NPI # 101-31-540-53    NPI#: 108-11-067-22

*The providers at NWIM provide courtesy insurance billing. **It is up to you, the patient/ representative/ guardian, to determine insurance coverage.** In order to ensure you are aware of your benefits, we request that you go through the following procedure before your visit.*

**Please follow the steps below to find out your benefits and eligibility by calling your insurance company's customer service line to answer the following questions.**

Name of insurance representative: \_\_\_\_\_ Date: \_\_\_\_\_

1. **Are Naturopaths an "Allowed Provider Type" in my plan?** YES / NO
  - a. **NOTE FOR PROVIDENCE:** Drs. Maeghan Culver and Stephanie Culver are contracted as primary care providers. Drs. Oni and Jameson are contracted as naturopathic physicians. Those who got their insurance through the marketplace can likely only see Drs Oni or Jameson.
  - b. **NOTE FOR MODA:** No provider at NWIM is contracted to see MODA BEACON plans.
2. **Is the doctor I want to see an In-Network/a preferred provider for my plan?** YES / NO  
For an In-Network doctor, I have \$\_\_\_\_\_ coverage. I have a \$\_\_\_\_\_ co-pay
3. **Coverage Start Date:** \_\_\_\_\_
4. **Yearly Deductible:** \$\_\_\_\_\_ **Amount Met:** \$\_\_\_\_\_
  - a. Does my deductible need to be met before coverage starts? YES / NO
5. **Is my plan centered on the calendar year?** YES / NO
  - a. If not, what is my plan year? \_\_\_\_\_
6. **Do I have any dollar maximums or visit limitations?** \_\_\_\_\_  
Are these combined with any other alternative care services? \_\_\_\_\_
7. **Will labs and imaging ordered by a naturopathic physician be covered?** YES / NO
8. **Other Provider Types:**

a. Do I have coverage for chiropractors?	YES/NO	Number of Visits/Amount: _____
b. Do I have coverage for acupuncture?	YES/NO	Number of Visits/Amount: _____
c. Do I have coverage for massage?	YES/NO	Number of Visits/Amount: _____
d. Are these visits shared?	YES/NO	