

13128 Totem Lake Blvd NE #104  
Kirkland WA 98034  
(425) 814.2045 phone ♦ (425) 814.2783 fax

**Insurance Benefits Questionnaire**

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's ID/Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Time Limit for Filing Claim: \_\_\_\_\_

Practice/Provider Name: \_\_\_\_\_ Tax ID# \_\_\_\_\_

Person You Spoke With at Ins. Co: \_\_\_\_\_ Date of Call \_\_\_\_\_

Policy Effective Date: \_\_\_\_\_

Are requested services covered on this policy? Yes No

Does this policy cover the category of provider you are looking to see? Yes No

Is a referral required to see this type of provider under this policy? Yes No

Is the provider a preferred provider with this insurance company? Yes No

If applicable, how are out-of-network services paid?

\_\_\_\_\_  
\_\_\_\_\_

Coverage details: \_\_\_\_\_

\_\_\_\_\_

Co-pay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Deductible Met: \_\_\_\_\_

Coinsurance: \_\_\_\_\_ % Benefit Maximum: \_\_\_\_\_/year