



Insurance Benefit Breakdown

Date: _____

Insurance company: _____

Insurance phone number: _____

Patient name: _____

Provider name: _____

Provider date of birth: _____ Provider SSN#: _____

“I am interested in seeing a dietitian who would be considered out of network. What would that mean in terms of my benefits?”

Deductible? _____

Percentage of coverage after deductible is met? _____

Is pre-authorization required? Yes / No

Is a referral required? Yes / No

Number of visits? _____

Per calendar year or per contract year?

Services covered (i.e. obesity, diabetes, etc.): _____

Any other requirements or restrictions? _____

How do I submit a superbill from the dietitian? _____

Name of customer service representative: _____

Reference number* for phone call: _____

(* highly recommended for disputes with reimbursements)