

OpenMind Medicine Krista Tricarico, ND

Health Insurance Information

Your Name _____

Policy Holder's Name (if other than you) _____

Policy Holder's Date of Birth _____

Relationship to You _____

Insurance Company _____

Your Member ID _____

I am happy to bill your insurance company for you, but you will need to verify coverage ahead of time. Please call the number provided on your card and ask the following questions:

1. When did my coverage begin and when is it valid through? _____
2. Do I need a referral from my primary care physician for naturopathic care? _____
3. Is Dr. Krista Tricarico considered In-Network or Out-of Network? _____
4. What is the % Covered? _____ Co-pay? _____ Yearly Max? _____
5. What is my deductible for the year and what portion of it has been met? _____
6. Are lab services covered and which lab is preferred? _____
7. What is the name of the representative you spoke with? _____ Date _____