INTEGRATIVE ACUPUNCTURE

Insurance Verification

Patient Name_____

Patient Address_____

City, State, Zip (must have)_____

Patient Phone Number_____

Patient Date of Birth_____Male_____ Female_____

Patient Subscriber # / ID #_____

Group #_____

Insured Name & ID# (if different from patient)_____

Insured Date of Birth (if different from patient)_____

Relationship to Insured Self _____Spouse_____Child_____Other_____

Single_____ Married_____ Other_____

Insurance Company Name_____

Insurance Company Phone # _____

Claim # if an accident_____

Date of Accident/Injury_____

TO BE COMPLETED BY OFFICE STAFF

No Coverage_____ Coverage_____

Deductible_____ Amount Met_____

Visits Per Year_____ Allowable %_____ Other_____

Acupuncture YES / NO Units / Visits_____

Office Visits YES / NO

PT YES / NO Units / Visits_____