Benjamin Dierauf, LAc
(925) 297-4785

Acupuncture Insurance Coverage Inquiry Form

Date: ____________

Name (as on Health Insurance Card): ____

Date of Birth: _____________

Home Address: ____
Number Street City State Zip

Health Condition for which you'd like treated: _________________________________

Marital Status: ____________ **Employment Status**: __________________

If your health plan is through someone else, we'll need the following info:

Relationship to Insured: ______________________

Insured Name: ____

Insured Date of Birth: _____________

Insured Address: ____
(if different) Number Street City State Zip

Please email or fax, along with photos or copies of the front and back of your Health Insurance Card, and we'll submit this information to our biller and should have a response for you within 2 working days. Please contact us if you have any questions.

Email: **office@acupuncture-balance.com** **Fax: (925) 403-1001**