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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.



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