

Acupuncture & Healthcare Center Insurance Verification

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Patient Phone #: _____

Patient Date of Birth: _____

Patient Subscriber # / ID# (if different from patient): _____

Group #: _____

Relationship to Insured: Self Spouse Child Other

Patient Status: Single Married Other

Insurance Company Name: _____

Insurance Company Phone #: _____

Claim # if an accident: _____

Date of Accident: _____

Other Info: _____

To be completed by office staff:

Deductibles: \$ _____ Amount met: \$ _____

Visits per year: _____ Allowable: % _____

Acupuncture: Yes No Units / Visits: _____

Office Visits: Yes No Units / Visits: _____