Acu-Health Center: Carol Rider, L.Ac., M.T.O.M.

Acupuncture Insurance Verification Form
Please Fax to 877-567-2073 or Email to acuhealthcenter1@yahoo.com, 48 hours prior to visit to avoid payment in full at time services are rendered.

Patient's Name:_____ DOB_____ Phone: _____

Name of Insured:_____ DOB_____

Group #_____ Group Name_____

Name of Insurance Company:_____ ID #_____

Insurance Address (back of card):_____

City:_____ ST_____ Zip_____

Phone # _____Fax #_____

FOR AUTO ACCIDENT ONLY: Please fill the above information and

Case or Claim #_____ Date of Accident:_____

By signing this form you acknowledge the above information regarding your policy and give consent to verify coverage.

X_____ _____
Patient Signature Date

For Office Use Only

This statement is regarding verification of your health insurance.

Based on your policy, your coverage consists of:

Deductible:_____Remaining:_____Amount Used:_____

Coverage consists of:_____%_____ (once deductible has been met)

Per calendar year, you are allowed _____visits.