Insurance Verification Form

Personal Information
First Name:
Last Name:
Relationship to Insured: *(Self)(Spouse)(Child)(Other)*
Your Phone Number:
Your e-mail Address:
Date of Birth: *(MM,DD,YYYY)*
Main Complain: *(Some insurance companies limit acupuncture benefits to certain conditions)*
Insurance Information
Type of Insurance: *(Major Medial Insurance)(No-fault auto)(Workers' Compesation)*
Insurance Company:
Your Member ID#: *(or Policy#)*

Workers' Compensation / Personal Injury (ONLY)

Phone for Provider Services: *(or main phone number on the back of your health insurance card)*
Date of Accident: *(MM/DD/YYYY)*
Case or Claim#:
Name of Case Manager:
First Name: Last Name: Phone number of Case Manager: