AUBURN ACUPUNCTURE HEALTH INSURANCE INFORMATION FORM

Please complete this form when you are a new patient who would like us to bill a health insurance plan for your acupuncture treatments and you are not insured on the plan (your spouse, parent, or guardian is) or when you are a current patient who had had a change in insurance (e.g. – change in group number, insurance company, addition of secondary benefits, etc.). Please submit this form to us with a copy of the front and back of your insurance card. Thank you.

PRIMARY INSURANCE INFORMATION

Patient Name ____ DOB ____________________

Patient's Employer ____________________________________ Work Phone ____________________

Primary Insurance Company __________________________________ Phone ____________________

Insurance Co. Address ____

Insured's Name (if other than patient) ____

Patient's Relationship to Insured _________________________ Insured's DOB ___________________

Insured's Employer ____________________________________ Subscriber ID ____________________

SECONDARY INSURANCE INFORMATION

Secondary Insurance __________________________________ Subscriber ID ____________________

Name of Secondary Insurance Policy Holder ____

Secondary Policy Holder DOB ____________________ Relationship to Patient ____________________

I understand that Auburn Acupuncture will bill my insurance company for this visit. I also understand that I am financially responsible for any deductible, copayment, or other costs that are not covered by my insurance company

Signature ____ Date ____________________