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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.

Email: [office@acupuncture-balance.com](mailto:office@acupuncture-balance.com)

Fax: (925) 403-1001