INSURANCE FORM

UNION CENTER FOR HEALING

Coverage is not guaranteed and needs to be verified with your health insurance plan. Some plans require a prescription for massage. Although acupuncture is generally a covered service, it is only covered for certain conditions.

Name ________________________________ Date of birth __________

Employer _____________________________ Single ____ Married ____

PRIMARY INSURANCE INFORMATION

Plan __________________ Subscriber ID # ____________________________(Include letters)

Group # ________________________ Phone # _________________________

Billing Address ____

Relationship to insured: Self _____ Spouse/DP _____ Child _____ Other______

PLEASE FILL OUT INFORMATION BELOW IF YOU DID NOT CHECK SELF

Name on plan if not self _____________________________ Date of Birth __________

Address (if other than yours) ____

Employer ________________________________ Phone # ______________________

SECONDARY INSURANCE INFORMATION

Plan __________________ Subscriber ID # ____________________________(Include letters)

Group # ________________________ Phone # _________________________

Billing Address ____

Relationship to insured: Self _____ Spouse/DP _____ Child _____ Other______

Name on plan if not self _____________________________ Date of Birth __________

Address (if other than yours) ____

Employer ________________________________ Phone # ______________________

PIP or L& I CLAIM

Claim #____

PIP/Auto/L&I Company Name ____

Billing Address: ____

Adjuster's Name ___________________________________ Phone number________________

Date of Injury ____________________________

Name of Insured if other than you: ____

Attorney/Office/Address/Phone#: ____

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PLEASE READ AND SIGN

In the event that my insurance coverage expires or denies payment, I understand that I am personally fully responsible for all fees incurred. I agree to release any medical information my insurance company, adjustor, or the attorney involved in my case may need in order to process payment. I assign some benefits to be paid to the above named provider.

Signature ____ Date __________