Jade Spring Wellness Center
ACUPUNCTURE • MASSAGE THERAPY • CHINESE HERBAL MEDICINE

ACUPUNCTURE/ORIENTAL MEDICINE INSURANCE VERIFICATION

W/C ____ P/I ____ Health ____

Patient's Name: _____ DOB: _____

HEALTH INSURANCE:

Insured: _____ SS# _____- _____- _____
Name of Insurance: _____ Phone #:_____
Billing Address:_____
City:_____ State:_____ Zip:_____
Policy #:_____ Group #:_____ Effective:_____
Employed By:_____
Acupuncture: Y/N Deductible Amount Has it been met? Y/N
Limits: $ amount max:_____ Amt/visit:_____ # of Visit: _____
Exclusions:_____
Massage:_____

AUTO INSURANCE (MED PAY):

Insured: _____ SS# _____- _____- _____
Name of Insurance: _____ Phone #:_____
Billing Address:_____
City:_____ State:_____ Zip:_____
Policy #:_____ Claim #:_____ Effective:_____
DOI _____
Employed By:_____
Adjuster:_____ Date:_____

WORKER'S COMPENSATION:

Name of Insurance: _____ Phone #:_____
Billing Address:_____
City:_____ State:_____ Zip:_____
Claim #:_____ WCAB #:_____ DOI:_____
Employer___:_____
Adjuster Name:_____ Written Authorization? Y/N
Referred by:_____
Verification done by:_____ Date:_____