YIN YANG ACUPUNCTURE CHANNEL, PLLC
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INSURANCE VERIFICATION FORM

Please fill in all lines below AND please include scans or very good photos of the front and back of your insurance card(s). If you have more than one card, please indicate which one is your primary provider.

Primary Insurance Policy

Name as it Appears on Your Insurance Card: _____

_____

Date of Birth: _____

Home Address on File with Your Provider: _____

_____

Insurance Provider: _____

Member ID: _____

Provider Phone Number: _____

Secondary Insurance Policy (optional)

Name as it Appears on Your Insurance Card: _____

_____

Date of Birth: _____

Home Address on File with Your Provider: _____

_____

Insurance Provider: _____

Member ID: _____

Provider Phone Number: _____

Please email completed form to YinYangChannel085@gmail.com