Arcadia Acupuncture Clinic

Outside Claim Information

Patient Name ______________________ Today's Date ____________

Was your injury a result of: ☐ Employment ☐ Motor Vehicle Accident ☐ Other

Date of Injury ______________________ Location (State) ____________

Have you received prior authorization for treatment? ☐ Yes ☐ No

If yes, please supply copy of authorization letter. If no, prior authorization is requested before service.

Insurance Company Name ______________________

Claims Address ______________________

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Claim Number ______________________

Claim Representative ______________________

Contact Phone Number ______________________

Contact Fax Number ______________________

Our office will submit claims on your behalf for the services provided, however your claim may not pay for everything that you or your health care provider may recommend. This is based on our experience and is not an official insurance decision. If you have questions about what your claim will and will not cover, please call your claims representative.

I, ______________________________, understand that my claim may not cover all services and products. I am responsible for any services, supplements or other products that are not reimbursed.

______________________________ ______________________

Patient Signature Date