

BRAZELIA MED SPA

Brazelia Lazzari, ND, OMD, AP

INSURANCE VERIFICATION FORM

Many insurance companies are providing coverage for acupuncture and some of the other therapies and treatments we use. Our Insurance Manager will gladly verify your insurance coverage after you complete and submit the short form. Please print, fill out and return to the address below.

Please fill in all information. Missing or incomplete information will delay your request. Thank You.

Full Name (Last Name, First Name): _____

Address 1: _____

Address 2: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Your DOB (Month, Day, Year): _____

SEX: Male Female

Patient, Subscriber# / ID: _____

Group #: _____

Insurance Type: _____

Insured Name & ID#(if different from Patient): _____

Relationship to insured: _____

Marital Status: _____

Insurance Company Name: _____

Ins. Co. Phone #: _____

Claim # if accident: _____

Date of Accident/Injury: _____

Condition or illness you are seeking treatment for: _____

Referred By: _____

Other Information: _____

By submitting this form, I understand that my personal information will be used ONLY for the insurance verification process. It will be accessible to the staff at Brazelia Med Spa and to a third-party biller.

I understand that I have the right to request any and all restrictions to the use of disclosure of my health information.