Third Space Wellness, LLC

INSURANCE VERIFICATION FORM

Insurance Co. Name: _____

Patient's Name: _____ Patient D.O.B.: _____

Member #: _____ Group #: _____

Insured's Name: _____

Relationship to Patient: _____ Insured's D.O.B.: _____

Insured's Employer: _____

Please complete and email this to info@thirdspacewellness.com and we will contact your provider to receive a quote of benefits for acupuncture covered in the office for therapeutic purposes.

Please review your policy or call your insurance company to double check your benefits as well. All calls to insurance companies are a "quote of benefits and not a guarantee of payment" as quoted by every insurance company customer service representative. Third Space Wellness will not be held responsible for denial of any claims. If your claim is denied, you are responsible for all fees incurred and payment will be due within 30 days of receiving a statement by mail.