UPTOWN
ACUPUNCTURE AND HERBS

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Auto Insurance Information Verification Form

You can use this form to verify your auto insurance benefits before your visit.

Patient name: _____ Date: _____

Phone Number: _____ Date of Birth: _____ Date of Injury: _____

Did the accident occur in WA state ❑ Yes ❑ No | If no, what state? _____

Your Insurance Company (or the car you were in): _____

Name of Insured: _____

Is there medical coverage? ❑ Yes ❑ No

If yes, how much? (they may not tell you) $_____

Adjusters Name: _____ Phone Number: _____ Claim # _____

Address to submit claims: _____ City: _____ State: ____ Zip: _____