Alternative Medicine Insurance Reimbursement Request Form

Full Name

Address

Phone Number

Email

Insurance Provider

Policy Number

Treatment Type (e.g. acupuncture, chiropractic, etc.)

Treatment Date(s)

Practitioner/Provider Name

Provider Address

Total Amount Paid

Reason for Seeking Reimbursement

Attach Receipts/Documentation

Choose File No file selected

Date of Submission

Signature