

Insurance Reimbursement Request

Name:	For office use only:
Phone:	Date requested:Request taken by (initial):
Email:	
Requesting (please check one or both of the below boxes): Invoice Treatment Notes	Date fulfilled: Fulfilled by (initial):
Date Range of request:	
Please initial each of the following statements:	
I understand that ABW is not a doctor's office and can n I understand that ABW can not and will not file, bill, or s company.	,
I have provided my personal email address above that motes will be sent to.	ny invoice and/or treatment
I understand that invoices and treatment notes will be s request.	ent to me within 48 hours of my
I understand that tips are not eligible for reimbursemen FSA or HSA cards.	t and that I cannot tip using my
I understand that it is my responsibility to file my invoice my insurance company for potential reimbursement.	e and/or treatment notes with
Signature:	

Note: If you fail to initial, sign, or provide any of the above information, your invoice and/or treatment notes will not be sent to you until this form is completed.