

Member to Member Reimbursement Sign-Up Form

1

Patient Name _____
Address _____

Phone/ email/ web _____
Signature _____ Patient Member # (required) _____

Number of planned sessions _____

Estimated Cost \$ _____

Requested Reimbursement \$ _____

Doctor IHA Member# _____
(Provider or General Member)

Clinic IHA Member# _____
(Corporate or General Member)

Corporate IHA Member# _____
(Chamber dealer)

2

Doctor Name and License # _____
Address _____

Phone/ email/ web _____
Signature _____ Member # (required) _____

3

Chamber Dealer Name _____
Address _____

Phone/ email/ web _____
Signature _____ Member # (required) _____

Please fax or mail to IHA Member Services: (323) 888-1591 fax or 15810 E. Gale #178 Hacienda Heights, CA 91745