

Please determine your massage benefits by calling the customer service # on your card.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone #: (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

Does your insurance policy cover Massage Therapy performed by an LMP? □Yes □No

Does Treatment have to be referred? □Yes □No

Does treatment have to be prescribed? □Yes □No

Who can refer/prescribe Massage Therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the Primary Care Physician (PCP)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the plan require pre-authorization? □Yes □No

Authorization and reports should be sent to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address City State Zip

(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone# Fax #

What is the annual Massage benefit and/or limits?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ($ amount and/or # of treatments)

Do the benefit limits include treatment by a P.T? □Yes □No / Or a Chiropractor? □Yes □No

What is the deductible? \_\_\_\_\_\_\_\_\_\_\_\_\_ Has it been met? □Yes □No

If the deductible has NOT been met, what is the remaining amount? $\_\_\_\_\_\_\_\_\_\_.\_\_\_\_

Is there a co-pay? □Yes □No If yes, how much $\_\_\_\_\_\_\_\_\_.\_\_\_\_

Does the LMP have to be a Preferred Provider? □Yes □No

Is one of our LMPs on the preferred provider list? □Yes □No

Teri Anderson, Diedra Dulaney, Sean Loehr, Amanda Robinson

Are there “out of network” benefits? □Yes □No If yes, what % \_\_\_\_\_\_\_\_\_\_%

Is the deductible the same? □Yes □No If no, the amount? $ \_\_\_\_\_\_\_\_.\_\_\_\_

Is the annual Massage benefit limit the same? □Yes □No If no, the amount? $\_\_\_\_\_\_\_\_\_.\_\_\_\_

Claims must be sent to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address City State Zip

Date Time AM/PM Person you spoke with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Please bring this form with you to your next massage appointment, so it can be added to your medical file.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_