evergreen massage therapy

Patient's Private Health Insurance Verification Form

Use to determine your massage benefits by calling the customer service # on your card and asking the following:

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. and/or a D.C.? □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 (see attached) on the preferred provider list? □Yes □No
Teri Green Michelle Murphy Diann Betz Carmen Foster Ann Nicewonger
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: ____/____/____

Thank YOU! Evergreen Massage Therapy
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