

# Insurance Verification Form

## For Private Health

Patient's Name: \_\_\_\_\_

Date of Call: \_\_\_\_\_ Person you spoke with: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Primary or Secondary Insurance: \_\_\_\_\_

Partner's name & Date of Birth, if using their benefits: \_\_\_\_\_

Does my policy cover massage therapy performed by a licensed massage therapist?

yes  no

If yes, are there any limits to my coverage? If YES, please specify: \_\_\_\_\_

Effective date of my policy: \_\_\_\_\_ Monetary limit: \_\_\_\_\_

Number of allowed visits per year: \_\_\_\_\_

Number of visits that have been used to date: \_\_\_\_\_

Is there a maximum yearly benefit for massage therapy or acupuncture?: \_\_\_\_\_

Are these limits strictly for massage therapy or do they also include acupuncture, physical therapy, or chiropractic care?  yes  no

Are these benefits for alternative health care taken from the same pool?  yes  no

Is a Primary Care Physician (PCP) referral required?  yes  no

What is the deductible?: \_\_\_\_\_ Has the deductible been paid?  yes  no

Will the deductible apply to the following year, if you begin to pay it in the last quarter of the present year?  yes  no

Is there a fixed dollar co-pay for an office visit?  yes  no

Co-pay amount: \_\_\_\_\_

What is the percentage of the coverage? \_\_\_\_\_%

Is there a preferred provider (PP) list for massage therapists?  yes  no

What are my benefits with a PP? \_\_\_\_\_

What are my benefits with a non PP? \_\_\_\_\_

Send bill to: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Electronic Claims payor#: \_\_\_\_\_