PRIVATE HEALTH INSURANCE VERIFICATION FORM

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

Does your insurance policy cover Massage Therapy performed by and 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? ___PCP, ___MD, ___DC, ___ND

Who is the Primary Care Physician? (PCP) ______________ Phone#_____________

Does the plan require pre-authorization? **Yes/No**

Who is responsible for pre-authorization? Doctor _____ Massage Therapist _____

What is the address, phone# and fax# authorization and reports should be sent to?

What are the annual Massage benefit limits? ___________________________________
($ amount and / or # of treatments)

What is your deductible? ____________ Has it been met? **Yes/No**

Is there a co-pay? **Yes/No** How much? _____________

Does the LMP have to be a preferred provider? **Yes/No**

Is Janice McClure on your list? **Yes/No**

Are there "out of network" benefits? **Yes/No**

If yes, what % __________________ Is the deductible the same? **Yes/No**

If no, Amount _____

Is the annual massage benefit limit the same? **Yes/No**

Date_____________ Person you spoke with _____________

____
Patient signature