

12th Avenue Massage Therapy Group

Insurance Verification Request

Patient Personal Information:

Name _____ Date of Birth _____

Address _____ Contact# _____

Insurance Information:

Type of Insurance:

- Commercial Insurance
 Workers Comp -if yes, what was the date of injury _____
 Personal Injury (PIP)- if yes, what was the Date of Accident _____
 Other _____

Insurance Company Name _____ Type _____

Policy # _____ Group # _____

Insurance Phone number _____ Adjuster name _____

Therapist Name (The massage therapist you are working with, if applicable)

To be filled out by billing service:

Date of verification _____ Time _____

I spoke with _____ Phone # _____

Is massage covered by a massage therapist? yes no

What percent is covered? _____% Are there any limitations? _____

Deductible met _____ Funds remaining _____

NOTES:

