Practitioner/Clinic Name: _____

Contact Information: _____

Billing Information

Patient Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Gender: _____ Marital status: _____ Date of birth: _____

Social security number: _____ Date of injury: _____

Referring healthcare provider: _____

Phone: _____ Email: _____

Address: _____

Primary Insurance Information

(e.g., Car Insurance if an auto accident, Worker's Comp if an on-the-job injury, Health Insurance if an illness, etc.)

Insurance company: _____ Phone: _____

Address: _____

Insurance ID# (include alpha prefix): _____ Group Plan #: _____

Name of insured (if other than you): _____

Relationship to insured: _____ Insured's SS#: _____

Insured's date of birth: _____ Insured's gender: _____

Adjuster's name: _____ Phone: _____ Fax: _____

Secondary Insurance Information (if applicable)

Insurance company: _____ Phone: _____

Address: _____

Insurance ID# (include alpha prefix): _____ Group Plan #: _____

Name of insured (if other than you): _____

Relationship to insured: _____ Insured's SS#: _____

Insured's date of birth: _____ Insured's gender: _____

Adjuster's name: _____ Phone: _____ Fax: _____

Practitioner/Clinic Name: _____

Contact Information: _____

Billing Information

Motor Vehicle Collision (Additional information is necessary if billing your car insurance)

Auto collision in what state? _____

Job-related collision? Yes ☐ No ☐

Was the collision your fault? Yes ☐ No ☐

PIP policy amount: _____ Dates of coverage: _____ PIP available: _____

MedPay policy amount: _____ Dates of coverage: _____ MedPay available: _____

Liability policy amount: _____ Dates of coverage: _____ Liability available: _____

Attorney Name (if applicable): _____ Date retained: _____

Phone: _____ Fax: _____ Email: _____

Address: _____

Worker's Compensation (Additional information is necessary if billing State or Federal Labor Insurance)

Have you received any massage/bodywork for this injury/claim? Yes ☐ No ☐

# of sessions: _____ Date claim opened: _____ Dates of coverage: _____

Private Health (Additional information is necessary if billing your health insurance)

Does the insurance plan cover massage therapy? Yes ☐ No ☐

Does it cover massage therapy provided by a massage therapist (LMT, LMP, RMT, CMT, etc)? Yes ☐ No ☐

Does it cover massage therapy for this condition (_____)? Yes ☐ No ☐

Does the treatment have to be referred? Yes ☐ No ☐ Prescribed? Yes ☐ No ☐

Does the treatment have to be pre-authorized? Yes ☐ No ☐

What is the annual massage therapy benefit (# of visits or $ amount)? _____

How much is remaining for this year? _____

Do the benefit limits include PT, DC as well? Yes ☐ No ☐ How much is remaining for this year? _____

What is the deductible? _____ How much as been satisfied to date? _____

Is there a co-pay? Yes ☐ No ☐ How much? _____

Does the massage/bodywork practitioner have to be a preferred/credentialed provider in the network? Yes ☐ No ☐

Is _____ a preferred/credentialed provider? Yes ☐ No ☐

Are there out-of-network benefits available? Yes ☐ No ☐

If yes, what % is covered/what is the co-insurance payment? _____

What is the deductible for out-of-network care? _____

How much has been satisfied to date? _____