Monroe Wellbeing Massage
at the
Wellbeing Center for Health

Patient Private Health Insurance Verification Form

Complete the following information

Patient's Name _____ 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 ☐

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 _____

_____
Patient Signature

_____
Wellbeing Staff Signature