Patient Information/Insurance Verification Form

To Be Completed by Provider **Provider Name, ID, Contact Info**

First Appointment Date _____ Today's Date _____

Patient's Name _____ DOB _____

Full Address _____

Phone _____ Cell _____

Send Front and Back of Insurance Card or Fill in the Following Information

Primary Insurance Information **Effective Date** _____

Insurance Company _____ Insurance Phone # _____

Claims Address _____

Claims Adjuster if PIP _____

ID# _____ Group # _____

Subscriber Name (if different from patient) _____ Relationship: Spouse Child Other

To Be Filled in by Patient/Policy Holder

In Network Massage Therapy Benefits? Yes No Out of Network Benefits? Yes No

Deductible _____ Met _____ Out of Pocket _____ Met _____ Copay/Co-ins _____

Visits per year _____ combined with _____ Used _____

Prescription Required: Yes No Doctor Referral Required: Yes No Referral # _____

Referring Physician's Name _____ Address _____

Pre Authorization Required: Yes No

Pre-Authorization # _____ # of visits _____ Dates _____ to _____

Diagnosis Code(s) _____

Notes :