Billing Information

Patient Information
Name: ____ Date: ______________
Address: _________________________ City/State: __________________ ZIP: ________
Phone: ______________________________ Email: ______________________________
Gender: _______________ Marital status: _______________ Date of birth: _____________
Social security number: __________________________ Date of injury: ________________
Referring healthcare provider: ____
Phone: ______________________________ Email: ______________________________
Address: ________________________City/State: _____________________ ZIP: ________

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: ________________________City/State: ___________________ZIP: __________
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: _________________________ City/State: __________________ ZIP: ________
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: ____________

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: ________________________ PIP available: _______________________
Dates of coverage: ____
MedPay policy amount: ____________________ MedPay available: ____________________
Dates of coverage: ____
Liability policy amount: ____________________ Liability available: ___________________
Dates of coverage: ____
Attorney Name (if applicable): __________________________ Date retained: ____________
Phone: ________________ Fax: ________________ Email: __________________________
Address: _________________________ City/State: ___________________ ZIP: __________

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 ☐

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? ____