The Massage Collective

Boulder Massage & NeuroMuscular Therapy

Motor Vehicle Accident Verification Form

Name: _____DOB:_____ Contact #:_____

Name of policy holder: _____ DOB: _____

Ins Co.:_____Phone #:_____

Claim #:_____Call Confirmation #_____

Adjustor Name:_____Adjustor Phone #:_____

Date of Accident: _____

Does insured have MedPay benefits? Yes No

If yes, are there funds available? Yes No

Does policy cover massage therapy performed by a licensed massage therapist? Yes No

Is CPT code 97140 covered by this policy? Yes No

Is CPT code 97124 covered by this policy? Yes No

Is a referral required? Yes No Are SOAP notes required to be sent w/ claim? Yes No

Send Claims to: _____ Fax# _____

Address: _____

City: _____State: _____Zip:_____

I understand that verification does not guarantee payment by my Insurance Provider. I understand that I am responsible for charges for services rendered at Boulder Massage not covered by my Insurance Provider.

Signature_____ Date_____

Please mail, email or drop off completed form to The Massage Collective.