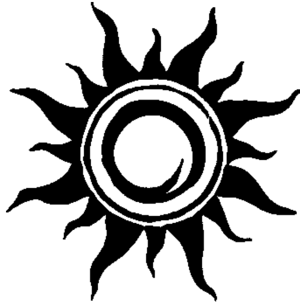

The Massage Collective

Boulder Massage & NeuroMuscular Therapy

Insurance Verification Form

Name: ____________________________DOB: ____________ Contact #: __________________

Name of policy holder: _______________________________ DOB: ____________________

Ins Company: __________________________________Phone#: ____________________________

Member/Policy Identification#: __________________________Group#: ____________________

Type of plan? HMO? PPO? Local Plus? When is the policy renewal date? ______________

Call Date: _____________Call Confirmation #____________________

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

Is CPT code 97124 covered by this policy? Yes No

Do I have a Co-pay? Yes No How much is the Co-Pay? $__________

What percentage of the massage treatment cost is covered? ________%

Is there a deductible on massage therapy? $___________ How much has been met? $_________

How many treatments allowed per year? __________ How many are left? ____________

How many 15 min. units can be billed per visit? _______

Is a referral required? Yes No Is precertification required? Yes No

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

Send Claims to: _______________________________________ Fax# _______________________

Address: ____

City: ________________________State: _____Zip Code: ___________

Payer ID # for Electronic Submission: _________________________

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

Signature______________________________ Date______________________________

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