~~~~~~For Office Only ~~~~~~

ID # _____

Patient Name: _____

DOB: _____

Massage Insurance Verification Form

*Please read this form in its entirety

Serenity Bodywork is more than willing to bill insurance for your massage therapy services; however, it is the patient's responsibility to be aware of their coverage, copays, deductibles or maximums. We need this form completed before we will schedule your massage appointment. Please also be aware that this is not a guarantee of payment. If an insurance company provides you with inaccurate information, they may not honor benefits quoted.

Please follow steps 1-7 when calling to find out benefits and eligibility. First call the number on the back of your insurance card listed as "customer/member services," benefits and eligibility or subscriber services and ask the representative the following questions:

Step 1: Insurance Company Name: _____ Member ID # _____

- When does my coverage begin and when does it renew?

  Beginning date of coverage: _____ Date benefits renew:_____
- Do I have Massage Therapy coverage when done by an LMT (Licensed Massage Therapist)?
  - YES, continue with Steps 3-7 ○ NO, continue to Step 2

Step 2:

- Are either of these CPT codes covered by my insurance plan? Also, are they covered out-of-network and/or in-network

  ○ 97124 ○ 97140 ○ 97010

Step 3:

- Do I need a referral and/or prior-authorization for the service?

  ○ If YES for a Referral – Do I need a referral from a chiropractor or Primary Care Physician? _____

  ○ If YES for Authorization – What company is the authorization needed from? _____

Step 4:

- What are my benefits for these services?

○ Co-insurance: $_____ ○ Co-pay: $_____ ○ Yearly Max: $_____ ○ Visit Max _____

Step 5:

- What is my deductible for the year and how much has been met so far?

  Deductible: $ _____ Amount met so far: _____

  Date the deductible restarts: ____/____/____
- Are any of these services subject to this deductible? ○ YES ○ NO

Step 6:

Date and name of representative: ____/____/____ _____

Step 7:

Address or Payor ID for the claim's submission: _____

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