WELLBEING
Center FOR Health

Patient Health Insurance Verification Form

Review Information:

Effective Date: ____________________

Plan Term:

Patient Name: ____________________ Patient Phone Number: ____________________

Insurance Company: ____________________ Patient DOB: ____________________

Subscriber ID: ____________________ Group Number: ____________________

Ins. Provider Phone Number: ____________________

Does treatment have to be referred or prescribed? ☐ Referred ☐ Prescribed

Does policy cover Manual Therapy (97140) by an LMP? ☐ Yes ☐ No

Does policy cover Massage Therapy (97124) by an LMP? ☐ Yes ☐ No

Does the plan require pre-authorization? ☐ Yes ☐ No ____________________
Pre-Authorization #

What is the annual Massage benefit and/or limits? ____________________
($ amount and/or # of treatments/# of treatments remaining to date)

Do the benefit limits include treatment by Physical, Speech, Occupational, Chiro, Pulmonary, Cardiac Therapy and or a D/C? ☐ Yes ☐ No

What is the individual deductible? ____________________ Met to date $ ____________________ ☐ Yes ☐ No

Co-pay: $ ____________________ Coinsurance split (Pymt/PR): % % $ ____________________

Max Out-pocket PCY: $ ____________________

Amount met to date: $

Out of Network benefits available? ☐ Yes ☐ No If yes, what %? ____________________

Is the deductible the same? ☐ Yes ☐ No If no, the amount? ____________________

Is the annual Massage beneift limt the same? ☐ Yes ☐ No If no, the amount?

Notes: ____________________

Mail claims to: ____________________

Address: ____________________ Fax Number: ____________________

Phone Number: ____________________

City/State/Zip: ____________________

Date: ____________________ Reference# ____________________

Wellbeing Staff Signature Insurance CSR Agent Name

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