



PRIVATE HEALTH INSURANCE INFORMATION FORM

www.allstarfitness.com

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL#: _____ HOME #: _____ WORK#: _____ DATE OF BIRTH: _____

SS#: _____ DATE OF INJURY: _____ REFERRING DOCTOR: _____

In Order To Bill Your Private Health CO. PLEASE ASK FOR AN INSURANCE VERIFICATION FORM and PLEASE COMPLETE ALL OF THE FOLLOWING:

| | | | |
|--|----------------|-----------------|---------|
| PRIMARY INSURANCE COMPANY NAME | | | PHONE#: |
| ADDRESS OF INS. CO: | CITY: | STATE: | ZIP: |
| INSURANCE ID: (alpha prefix) # | | GROUP /PLAN #:: | |
| NAME OF INSURED: | DATE OF BIRTH: | SS#: | |
| YOUR RELATIONSHIP TO INSURED? <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/PARTNER <input type="checkbox"/> CHILD INSURED SEX? <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE | | | |
| INSURED'S EMPLOYER OR SCHOOL | | | PHONE#: |
| DO YOU HAVE SECONDARY COVERAGE WITH ANOTHER INSURANCE COMPANY? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Please complete below: | | | |
| SECONDARY INSURANCE COMPANY NAME | | | PHONE#: |
| ADDRESS OF INS. CO: | CITY: | STATE: | ZIP: |
| INSURANCE ID: (alpha prefix) # | | GROUP /PLAN #:: | |
| NAME OF INSURED: | DATE OF BIRTH: | SS#: | |
| YOUR RELATIONSHIP TO INSURED? <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/PARTNER <input type="checkbox"/> CHILD INSURED SEX? <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE | | | |
| INSURED'S EMPLOYER OR SCHOOL | | | PHONE#: |

PLEASE READ AND SIGN BELOW.:

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

SIGNATURE: PATIENT/PARENT/GUARDIAN _____

DATE: _____



VERIFICATION FORM

DOES YOUR INS. POLICY COVER MASSAGE THERAPY PERFORMED BY AN LMP?

YES NO

DOES TREATMENT HAVE TO BE REFERRED?

YES NO

DOES TREATMENT HAVE TO BE PRESCRIBED??

YES NO

WHO CAN REFER/PRESCRIBE MASSAGE THERAPY?:

PCP MD DC ND

PRIMARY CARE PHYSICIAN (PCP): _____ **PHONE#:** _____

PRE-AUTHORIZATION

DOES THE PLAN REQUIRE **PRE-AUTHORIZATION**?

YES NO

WHO IS RESPONSIBLE FOR **PRE-AUTHORIZATION**?

THE DOCTOR THE MASSAGE THERAPIST

SEND AUTHORIZATION REPORTS TO _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE#: _____ FAX#: _____

BENEFIT AMOUNTS

ANNUAL MASSAGE BENEFIT LIMITS (\$ amount and/or # of treatments): _____

DO THE BENEFIT LIMITS INCLUDE TREATMENT BY A P.T. AND/OR A D.C.??

YES NO

WHAT IS THE DEDUCTIBLE? _____ HAS IT BEEN MET?

YES NO If NO remaining amount? _____

IS THERE A CO-PAY?

YES NO If YES how much? _____

DOES THE LMP HAVE TO BE A PREFERRED PROVIDER?

YES NO

IS _____ LMP ON THE LIST?

YES NO

ARE THERE "OUT OF NETWORK" BENEFITS?

YES NO If YES what% _____

IS THE DEDUCTIBLE THE SAME?

YES NO If NO amount? _____

IS THE ANNUAL MASSAGE BENEFIT LIMIT THE SAME?

YES NO If NO amount? _____

CLAIMS SHOULD BE SENT TO _____

DATE: _____ PERSON SPOKE WITH: _____

SIGNATURE: PATIENT/PARENT/GUARDIAN _____