Provider Name: ______________________ Phone:________________ Date:___________

Massage Therapy Insurance Verification			
Patient Name:	DOB:	Id#:	Group#:
Insurance company:			
Primary Policy Holder:	DOB:	Id#:	Group#:
Does Deductible Apply to Massage:	☐ Y ☐ N		
Co-pay:		Co-Ins:	
How many visits per year:			
Prior Authorization Required?	☐ Y ☐ N		
Out of network Benefits?	☐ Y ☐ N	Deductible:	Co-pay: