

Holistic Massage & Wellness Clinics

Major Medical Coverage Verification Form

Phone (954) 491-2225 Fax (954) 491-6862

Name: _____

Address: _____

Phone: _____

Date of Birth: _____

Insurance Company: _____

Policy Number: _____

Questions to ask your insurance company before contacting us:

Do I have massage therapy benefits? Yes No

Do I have a deductible? Yes No Annual deductible _____

Have I met it yet? Yes No Balance remaining _____

Is it per calendar year (ie: January-December)? Yes No Other _____

Is there a limit to the number of visits I can receive? Yes No Number of visits _____

Is there a maximum dollar amount per year that my plan will pay towards this treatment? Yes No \$ _____

What percentage does my insurance cover? (this is only if you are submitting the bills yourself) _____ %

Do I have a copay for each visit? (this is only if you are submitting the bills your self) \$ _____

Do I need a prescription from my doctor or chiropractor to make the visit medically necessary? Yes No

Do I have out-of-network benefits for massage therapy? Yes No