
# Major Medical Coverage Verification Check List

Name: _____

Address: _____

Phone: _____

Date of Birth: _____

Insurance Company: _____

Policy Number: _____

**QUESTIONS TO ASK YOUR INSURANCE COMPANY TO CONFIRM YOUR BENEFITS PRIOR TO VISITING 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: Jan-Dec)? 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 co-pay for each visit? (applies if you are submitting the bills yourself) $_____

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 _____

Please fax completed form to (360) 658-6271 or bring to your first appointment