Massage Center of Bellevue
37-103rd Ave NE Suite A
Bellevue, WA 98004
425.451.1171

Insurance Verification & Information

Patient Name: ________________________________ Date of Birth: ______________________________

Insurance Payor:______________________________ ID/Claim #: _________________________________

Group #: ___________________________________ Group Name________________________________

Primary Insured: ____ Date of Birth: _________________

Date of Injury: ______________________________ Employer: __________________________________

Claim Adjustor Name & Phone: ____

Insurance Verified on: _______________ ☐ online ☐ phone- *name of ins. rep*: ______________________

Massage Covered: Yes No By LMP: Yes No In-Network: Yes No

Co-pay: ______________ % Covered: ____________________

Deductible: $____________ Met for Year: $____________________

Maximum Benefits for Massage: Is this a combined Outpatient Rehab Benefit?: Yes No

________Visits Per Calendar Year ________Used to Date

$_______Per Calendar Year ________ Used to Date

Referral/Rx Required: Yes / No Medical Necessity: Yes / No

Release of Information & Financial Policy

Permission to Bill Insurance:
Massage Center of Bellevue will bill directly to and is authorized to receive payment from my insurance company. In the event that the insurance company makes direct payment to me for services rendered, I agree to promptly send payment to the Massage Center of Bellevue. I agree to make all copayments owed at the time of service.
Patient Responsibility:
The billing department will make all reasonable atempts to collect payments due. If they are unable to collect from my insurance company, I understand that I am responsible for all fees for services rendered. Also, it is my responsibility to verify that my provider is in my insurance network.
Release of Information:
I hereby authorize Massage Center of Bellevue tot release information contained in my medical record to my insurance company for the express purpose of obtaining payment for services rendered in this office. I also authorize the insurance company or attorney to remit payment directly to Massage Center of Bellevue.

Signature: ____ Date: __________________________

The benefits acquired by the Massage Center of Bellevue are not a guarantee of payment from your insurance company. Your insurance company may change your benefit payment at any time- please be aware that benefits quoted may be different upon receipt of your explanation of benefits. As the patient, it is your ultimate responsibility to ensure you have benefit coverage for massage therapy before your first date of service. Should payment be reduced or denied by your insurance company, you are responsible for payment on any balances due to the Massage Center of Bellevue.
Patient Signature: ________________________Date: ________________________________