



General Insurance Verification Form

"I'm calling to check the massage therapy benefits performed by a massage therapist."

Does my 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

Who is the Primary Care Physician(PCP)? _____ Phone# _____

Does the plan require pre-authorization? Yes No

Who is responsible for pre-authorization? Doctor Massage therapist

What is my annual Massage benefit limit? _____
(\$ amount and/or # of treatments)

Do the benefit limits include treatment by a pt and/or dc? Yes No

What is the deductible?

Has it been met? Yes No If no, remaining amount? _____

Does the LMP have to be a preferred Provider? Yes No

Is there a copay? Yes No If yes, how much? _____

Is Jennifer Giuntini, LMP on the list? Yes No

Are there "out of network" benefits? If yes, what % _____ Yes No

Is the deductible the same? Yes No
In no, amount? _____

Is the annual Massage benefit limit the same? Yes No

Name of the person you spoke with: _____

Signature: _____ Date: _____