Eagle River Therapeutic Massage

ERTM

Insurance Benefits Verification Form

Patient Name ______________________________

Address ______________________________

Social Security # ______________ Date of birth ______________

Work phone ______________ Home phone ______________

Referring Physician ______________ Dr.'s phone ______________

Insurance Information:

Insured's name: ______________________________

Insured's Date of Birth: ______________ Insured's SS# ______________

Address: ______________________________

Work phone: ______________ Home phone ______________

Claim number or ID number ______________ Group number ______________

Allowable benefits: ______________ Yearly deductible: ______________

Has it been met? ______________ Co-pay: ______________

Name of person you talked to at your insurance company: ______________

Date and time of conversation: ______________

Follow up/ comments: ______________

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