INSURANCE VERIFICATION FORM

HEALTH INSURANCE E.I REGENCE

FIRST NAME____

LAST NAME____

DATE OF BIRTH ____

INSURANCE NAME AND ID# WITH PREFIX ____

HAVE YOU MEET YOUR DEDUCTIBLE? ____

HOW MANY VISITS A YEAR AVAILABLE?
COMBINED?____

DO YOU HAVE REFERAL? ____

AUTO AND WORK INJURY (PIP AND LNI)

FIRST NAME ____

LAST NAME____

DATE OF BIRTH____

SSN____

CLAIM NUMBER____

CLAIM MANAGER NAME____

CLAIM PHONE NUMBER____

CLIENT INFORMATION

TODAY'S DATE_____________________________

FIRS AND LASAT NAME____

GENDER____________________

HOME ADDRESS____

CELL PHONE NUMBER_______________________________(REQUIRED)

EMAIL ADDRESS____

DATE OF BIRTH____

HOW DID YOU HEAR ABOUT US? ____

I understand that missed or cancelled appointments (medical emergencies excluded) without 24-hour notice area subject to payment in full.

Signature ____ Date______________________

PLEASE FAX YOUR FORM TO 253-630-6624

EMAIL TO info@bodyworksmc.com

GENERAL QUESTIONS: 253-630-6614

PLEASE BOOK ONLINE FOR FASTER SERVICE

BODY WORKS MASSAGE CLINIC

253-630-6614