

Insurance Pre-Approval Form

Entry Date: _____

Patient's Name: _____

Phone: _____

Social Security No.: _____

Date of Birth: _____

Employer: _____

Phone: _____

Referring Physician: _____

Phone: _____

Date of Injury: _____

Insured's Name: _____

Phone: _____

Social Security No.: _____

Date of Birth: _____

Insurance Company: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Plan #: _____

Claim #: _____ Member #: _____

Group #: _____ I.D. #: _____

Type of Insurance: Group PIP/Auto Workers' Compensation

Effective Date of Policy: _____

Is There A Deductible? Yes No Amount: _____

Is The Deductible Met? Yes No Amount Remaining: _____

Co-Pay Amount: _____ Maximum # of Visits: _____

Maximum Dollar Amount: _____

Percentage Policy Pays for the Massage Services: _____

Adjuster's Full Name: _____

Phone #: _____ Extension #: _____

Time and Date of Call: _____

Approved For: _____

Send: Notes: _____ Rx: _____ Interim Report: _____

Initial Report: _____ Progress Report: _____

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