Andrea Linnes-Bagley, CMT 612-568-4486

Insurance Questionnaire

The following questions are necessary so that we may properly file insurance for you. These questions are taken directly from the insurance form that we fill out and file for you. Please answer as completely as possible.

Type of Insurance: Medicare____ Medicaid____ CHAMPUS____ CHAMPVA____
Other____
Insured's Policy Group or FECA number: _____
Claim # (if Auto): _____
Insured's Name (as on card): _____DOB_____
Insured's Employer or School name: _____
Insurance Plan name or Program name: _____
Patient's Address:
Street_____ City_____ State ___ Zip_____
Insured's Address (if different from patient)
Street_____ City_____ State ___ Zip_____
Patient Relationship to Insured: Self____ Spouse____ Child____ Other____
Patient Status: Single, Married, Other, Employed, Full-time Student, Part-time Student
Is the condition we are treating related to: Employment____ MVA____ Other____
If another kind of accident, what type?: _____
Is there another health benefit plan?: _____

Patient's or Assigned Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. This is to serve as a long term authorization card.

Signed_____ Date_____

Insured's or Assigned Authorized Person's Signature: I authorize payment of medical benefits to Healing Hands Therapeutic Massage for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed_____ Date_____

Patient's or Assigned Authorized Person's Signature: I understand that in the event that my insurance company denies payment or makes a partial payment, I agree to be and remain responsible for the balance.

Signed_____ Date_____

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