

# Insurance Verification

## Emerald Vine Massage

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1. Does your insurance policy cover Massage Therapy performed by an LMP?  Yes  No  
(LMP = Licensed Massage Practitioner Some insurances only cover massage by a PT, DC, or MD)
2. Does treatment have to be referred?  Yes  No
3. Does treatment have to be prescribed?  Yes  No
4. Who can refer/prescribe Massage Therapy?  PCP  MD  DC  ND  ARNP  
(PCP = Primary Care Provider, MD = Medical Doctor, DC = Chiropractor, ND = Naturopath, ARNP = Nurse Practitioner)
5. Who is the Primary Care Provider (PCP)? \_\_\_\_\_ Phone: \_\_\_\_\_
6. Does the plan require pre-authorization?  Yes  No
7. Who is responsible for pre-authorization?  The Doctor  The Massage Therapist
8. What is the address, phone number, and fax number authorization and reports should be sent to?  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
9. What is the annual massage benefit limit? \$ Amount: \_\_\_\_\_ # of Treatments: \_\_\_\_\_
10. Do the benefit limits include treatment by a PT and/or DC?  Yes  No  
(It is possible that your insurance plan lumps massage visits together with PT and/or DC visits. It is also possible that your PT or DC may be using some massage in your treatment, billing your insurance agency for massage and, thus, maxing out your allowed massage treatments)
11. What is the deductible? \_\_\_\_\_  
Has the deductible been met?  Yes  No  
If "No," what is the remaining amount? \_\_\_\_\_
12. Is there a co-pay?  Yes  No  
If "Yes," what is the amount/percentage? \_\_\_\_\_
13. Does the LMP have to be a preferred provider?  Yes  No  
Is Shaina M. Akidau, LMP on the list?  Yes  No
14. Are there out-of-network benefits?  Yes  No  
If "Yes," what is the % is covered? \_\_\_\_\_  
Does the deductible remain the same?  Yes  No  
If "No," amount: \_\_\_\_\_  
Is the annual massage benefit limit the same?  Yes  No
15. Where should claims be sent? Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

Date of Verification Call: \_\_\_\_\_ Time: \_\_\_\_\_ Person You Spoke With: \_\_\_\_\_

Patient Signature: \_\_\_\_\_