Power of Therapeutic Touch
Anna Yarkovoy LMT
NPI 1609287754

Ph: 509-425-4314
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annayarmassage@gmail.com

INSURANCE VERIFICATION-PATIENT FORM

Massage Therapy

Verification instructions

Our office is set up to receive direct payment from insurance companies. To create the best opportunity for reimbursement from your insurance carrier, we ask that you do the following:

- Call the number on the back of your insurance card and determine your massage therapy coverage and provider stipulations (see questions below). Coverage depends on your insurance company and the specific plan you have chosen. Answers to the questions below will help you determine the amount of coverage available and identify your financial responsibilities so that you may budget for your massage therapy services.
- Record the name of the person you speak with and the time and date of the call for future reference, if necessary. You may need to contact them in the future if it becomes necessary to contest the reimbursement amount.
- Obtain a current prescription for massage therapy from a primary health care provider such as a physician or a chiropractor. **The prescription must include a diagnosis, the type of treatment prescribed, and the frequency and duration of the treatment. The date of the prescription and the duration of treatment as prescribed must cover all dates of service that are to be billed.**
- All deductibles and co-pays are due at the time of service. Know what they are and come prepared to pay at your appointments. Cash, or Visa/MC/AX/Discover accepted.
- Remember, all services provided are your responsibility regardless of insurance reimbursement. Any dates of service that are not covered by the prescription or that do not fall within your insurance plan's covered services will be billed back to you.

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Questions for the insurance representative

Patient Name:	
Insurance ID#	Group Plan#
Name of Representative:	Date: Time:

1. Does my insurance plan cover massage therapy? Yes ☐ No ☐
2. Does it cover massage therapy provided by a massage therapist? (LMP, LMT) Yes ☐ No ☐
3. Does the treatment have to be referred? Yes ☐ No ☐
4. Does the treatment have to be prescribed? Yes ☐ No ☐
5. Who can refer/prescribe massage therapy? MD ☐ DC ☐ ND ☐ PA ☐ Other ☐
6. Does the plan require pre-authorization? Yes ☐ No ☐
7. Who is responsible for pre-authorization? ☐
8. What is the annual massage therapy benefit limit? $ amount ☐ # visits ☐
9. Do the benefit limits include treatment by PT/OT/DC as well? Yes ☐ No ☐
10. What is Deductible? Has it been met? If not, how much is it remaining? ☐ Yes ☐ No ☐
11. Is there a co-pay? Co-Insurance? If yes how much? ☐ Yes ☐ No ☐
12. Does the massage therapist have to be a preferred/credentialed provider with this insurance company/network? Yes ☐ No ☐
13. Is Anna Yarkovoy LMT (NPI 1609287754) on the list? Yes ☐ No ☐
14. Are there out-of-network benefits available? If yes, what % ☐ Yes ☐ No ☐
    a. Is the deductible the same? Yes ☐ No ☐ If not, the amount? ☐
    b. Does the annual massage benefit the same? Yes ☐ No ☐ If not, the amount? ☐
15. What is the address, phone#, Fax#: the authorization, claims and reports should be sent to?

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This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Consent to Collect and Exchange Personal Information

Message to the plan ember, spouse and/or dependent regarding personal information:

- Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting auding and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent

Use of personal Information

I authorize my healthcare provider to collect, use, and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

Proposed Use of Personal Information

I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government.
- Benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

Retention and Discloser of Information

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that the photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

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Additional Consent Applicable to Plan Members Only

I Confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my plan sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my plan sponsor, for that purpose.

I ACCEPT THE TERMS AND CONDITIONS YES ☐ NO ☐

Benefit Assignment Form

Express Consent

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event the insurer/plan administrator declines my claim(s), I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this assignment that any benefit payment made in accordance with this assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by the provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator. If I am a spouse or dependent, I confirm that the plan member authorizes me to execute an assignment of benefit payments to the Provider.

I ACCEPT THE TERMS AND CONDITIONS YES ☐ NO ☐

Signature: _____