# Motor Vehicle Accident Verification Form

Name: _____DOB:_____ Contact #:_____
Name of policy holder: _____ DOB: _____
Ins Co.:_____Phone #:_____
Claim #:_____Call Confirmation #_____
Adjustor Name:_____Adjustor Phone #:_____
Date of Accident: _____

Does the insured have MedPay benefits?

Yes No

If yes, are there funds available?

Yes No

Does policy cover massage therapy performed by a licensed massage therapist? Yes No
Is CPT code 97140 covered by this policy? Yes No
Is CPT code 97124 covered by this policy? Yes No

Is a referral required? Yes No Are SOAP notes required to be sent w/ claim? Yes No
Send Claims to: _____
Fax# _____
Address: _____
City: _____State: _____Zip:_____

I understand that verification does not guarantee payment by my Insurance Provider. I understand that I am responsible for charges for services rendered at Dana G Massage Therapy not covered by my Insurance Provider.

Signature_____ Date_____

Please mail, email or drop off the completed form to Dana G Massage Therapy

Dana Golebiewski
4710 Table Mesa Suite B
Boulder, CO 80305
danagmassag@gmail.com.