INSURANCE BILLING QUESTIONNAIRE

Patient Name: _____

Street Address: _____, Suite/Apt; _____

City: _____, State: _____, Zip: _____

Date of Birth: _____, Social Security: _____

Home Phone: _____, Work Phone: _____, Cell Phone: _____

Sex: _____, Marital Status: _____

INSURANCE IMFORMATION

Insurance Carrier Name: (Auto, Work Comp., etc.) _____

Insurance Carriers Street Address: _____, Suite/Apt; _____

City: _____, State: _____, Zip: _____

Type of Injury (Workman's Comp., Auto, etc.): _____

Date of Injury: _____, Claim #:_____

Adjusters Name: _____

Adjusters Phone #: _____

ASSOCIATIONS

Employers Name: _____

Employers Street Address: _____, Suite/Apt; _____

City: _____, State: _____, Zip: _____

Supervisors Name: _____, Employers Phone: _____, Ext _____

Medical Insurance Carrier Name (Priority Health, BCBS, etc.): _____

Policy Numbers/Group Numbers: _____

I authorize DISCOVER Massage Specialists L.L.C. and Integrity Medical Management Solutions to use any and all information I provide for the use of billing my insurance company for the purposes of Massage Services or any related treatments. I also realize that I will be responsible for the difference between what the insurance company covers and the actual retail cost of services provided.

Signature: _____***, Date:*** _____

FAX TO: (231) 922-3484