TOTAL MUSCLE CARE

NYSHIP ELIGIBILITY & INSURANCE INFORMATION FORM

Patient Name: _____ Date of Birth: _____

Phone: _____ Date: _____

Email: _____

NYSHIP INSURANCE INFORMATION

Insurance Carrier / Plan: ■ NYSHIP – Empire Plan ■ Other: _____

Member ID #: _____ Group #: _____

Name of Policyholder: _____ Policyholder DOB: _____

Relationship: ■ Self ■ Spouse ■ Child/Dependent ■ Other: _____

Employer / Retirement System: _____

OTHER INSURANCE / MEDICARE

Do you currently have **Medicare**? ■ No ■ Yes – Part A ■ Yes – Part B ■ Medicare Advantage

Medicare ID, if applicable: _____

Do you have any **other health insurance coverage**? ■ No ■ Yes

Insurance Company: _____ Member ID #: _____

Is NYSHIP your: ■ Primary Insurance ■ Secondary Insurance ■ Unsure

ELIGIBILITY & BENEFIT INFORMATION

Have you received massage therapy, manual therapy, physical therapy, chiropractic care, or other rehabilitation services during this calendar year? ■ No ■ Yes

If yes, approximately how many visits? _____ Provider/Facility: _____

Have you been informed that you have: ■ Deductible ■ Copayment/coinsurance ■ Annual visit limitation ■ Referral/prescription requirement ■ Prior authorization requirement ■ Unsure of benefits

PATIENT ACKNOWLEDGMENT

I understand that insurance eligibility and benefit information may change at any time. Verification of benefits or eligibility **does not guarantee payment** by NYSHIP, UnitedHealthcare, Medicare, or any other insurance carrier. I am responsible for providing accurate and current insurance information, including Medicare or other primary/secondary coverage. I authorize Total Muscle Care / Toni Marie Campiglia, LMT to verify my insurance eligibility and benefits and to submit claims for covered services when appropriate. I understand that I may be financially responsible for services that are denied, non-covered, exceed available benefits, or are applied to my deductible, subject to applicable insurance contracts and laws. I agree to notify the office of any change in coverage.

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Eligibility Verified Date: _____ Verified By: _____

Coverage Active: ■ Yes ■ No Primary/Secondary Status: _____

Deductible: _____ Deductible Met: _____

Copay / Coinsurance: _____ Visit Limit / Remaining: _____

Referral / Prescription Required: ■ Yes ■ No ■ Unknown Authorization Required: ■ Yes ■ No ■ Unknown

Reference / Confirmation #: _____

Notes: _____

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