Insurance Intake Form

Betsy George, Licensed Massage Therapist

For health insurance please fill out information below. If it is an auto insurance claim, please fill out section 2. If it is a workplace injury or L&I claim, please fill out section 3.

Section 1: *Health Insurance*

Name _____ Date _____
Address _____ Phone _____
Date of birth _____ Date of Injury _____
Referring Physician _____ Physician's Phone _____
Insurance Co. Name _____ Phone: _____
Address for Claims _____
I.D.# _____ Group/Plan# _____
Name of insured (if not yourself) _____
Insured's Address _____
Insured's Phone _____ Insured's date of birth _____
Your Relationship to Insured ☐ self ☐ spouse/partner ☐ child
Insured's Employer or School _____

Section 2: *Auto Insurance or PIP (Personal Injury Protection)*

Date of Injury _____
Were you the driver or passenger? _____
Do you have PIP coverage? ☐ yes ☐ no
Insurance Co. (your PIP or insurance for car that accident occurred in) _____
Address for Claims _____
Is insurance in your name? ☐ yes ☐ no
If not, name of Insured _____
Insured's Address _____
Insured's date of birth _____
Referring Physician _____
Physician's Phone _____

Section 3: *Labor and Industries (Workplace Injury)*

Employer _____
Date of injury _____
Have you opened a claim? ☐ yes ☐ no
Is this claim open with a WA State L & I or is it with a self-insured company? _____
Claim # _____ Address for Claims _____
Referring physician _____
Physician's phone _____