TEAMSTERS LOCAL 671A HEALTH SERVICES AND INSURANCE PLAN
22 BRITTON DRIVE
BLOOMFIELD, CT 06002
PH: 860-289-3409
FAX: 860-528-3658

MASSAGE THERAPY REIMBURSEMENT FORM

A PRESCRIPTION FROM A REFERRING PROVIDER WITH A MEDICAL DIAGNOSIS IS REQUIRED. THE PRESCRIPTION MUST INDICATE THE DURATION OF TIME FOR EACH MASSAGE AND THE FREQUENCY OF VISITS IN ORDER FOR CLAIMS TO BE CONSIDERED.

PART 1 – MEMBER INFORMATION

MEMBER NAME:_____ID#_____

PART 2 - PROVIDER INFORMATION

CLAIMAINT'S NAME_____
THERAPIST'S NAME AND SIGNATURE_____
NAME OF PROVIDER:_____
ADDRESS:_____
_____
PHONE NUMBER:_____
THERAPIST LICENSE NUMBER:_____

DATE OF VISIT	LENTH OF VISIT	TYPE OF MASSAGE	BASE COST	TAX	TIP	TOTAL PAID