Kali Lane, LMT
Clinical Massage Specialist
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INSURANCE CLAIM FORM

Client Name: ____ Date of Birth: ________________________

Mailing Address: ____

City, State, Zip: ____

Phone Number: _____________________________________ Alternate Phone: __________________________________

Insurance Company: ____

Claim Adjuster/Representative: ____

Insurance Company Phone Number for Providers: ____

Is this claim for ☐ Motor Vehicle Accident ☐ Workman's Compensation ☐ Personal Insurance

Claim number: __________________________________ Date of Accident/Injury: ______________________________

Referring Physician: ____

Company Name: ____

Address: ____

City/State/Zip: ____

Phone Number: ____