



MEDICAL MASSAGE THERAPY CLAIM FORM

To be completed by Patient or Massage Therapist:

HEALTH PLAN ID \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

PATIENT DATE OF BIRTH \_\_\_\_\_

MEDICAL SYMPTOMS REQUIRING TREATMENT \_\_\_\_\_

PROCEDURE CODE	DATE OF SERVICE	CHARGE
97124		
97124		
97124		
97124		
97124		
97124		

TOTAL CHARGE: \$ \_\_\_\_\_

By signing, I am certifying that the above information is true and accurate.

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date

**Please attach receipt(s) from a licensed massage therapist, including the therapist’s complete name, address, phone number, and license number, and submit with this form.**

Remittance of this form is not a guarantee of payment. All claims are subject to review of the service(s) submitted and requires that the patient is a covered MUS Choices medical plan member on the date of service. The patient will be reimbursed the allowed amount/visit, minus the applicable massage therapy copay/visit. The patient is responsible for the applicable copay/visit, which is subject to out-of-pocket and outpatient rehabilitative services visit maximums, and any balance above the allowed amount/visit. There is a combined maximum of 30 outpatient rehabilitative services visits per plan year (July 1 – June 30). **NOTE:** Payment in full may be required at the time of service.

Massage therapy claims should be submitted to your medical plan claims administrator (BlueCross BlueShield). See the mailing address on the back of your medical plan identification card. Keep a copy of this completed form and the receipt(s) for your records.