PULLMAN REGIONAL HOSPITAL

Massage Service / Not to bill Insurance

Patient Name _____

Date of Service _____

Non-Covered Service _____

Estimated Charges of Non-covered Services _____ Patient Initials here _____

Health Plan _____ Member ID _____

You are requesting that we do not bill your health insurance as you do not want to have them apply towards your benefits. Your health and well being are our first priority. Therefore, we are not refusing to provide these services. If you choose to be treated, you will be responsible for the payment of this account.

□ I wish not to bill my insurance for this service as I do not want them to apply towards my benefits.

□ Other: (Please explain in detail) _____

_____

Frequency _____ How many times a week _____

Signed _____ Date_____

Relationship _____
(Patient / Representative)

Witness _____ Date_____

Therapist Review with patient if no order

_____

_____

Initial Therapists _____ Patient Initials _____

Revised: 04.07.17