MVA Insurance Information

Muscle Matters

Please print clearly.

Name:
Phone:
Email:

Date of Accident:
Claim Number:
Insurance Company:
Contact Name at Insurance Company:
Contact's Phone:
Contact's Fax:

For Office Use Only

Direct Billing Authorization

Muscle Matters

Please print clearly.

Since the motor vehicle accident, have your injuries been assessed?

☐ Yes ☐ No

If yes, please indicate which health care provider conducted the assessment:

☐ Medical Doctor ☐ Physiotherapist ☐ Chiropractor

Name of the facility that conducted the assessment:

Has the health care provider referred you for Massage Therapy?

☐ Yes ☐ No

Do you have extended health benefits?

☐ Yes ☐ No

Insurance Company	Member ID
Policy #	Your Date of Birth

Are you the primary insured member on this plan?

☐ Yes ☐ Spouse of Primary Member ☐ Child/Dependant of Primary Member

Primary Member's Name

I declare that the information provided is true and accurate to the best of my knowledge. I am responsible to immediately update Muscle Matters of any and all changes to my insurance coverage, treatment plan, etc.

I authorise Muscle Matters to direct bill my insurance company for my massage therapy treatments.

I understand that I am responsible for paying for my treatment should coverage be denied for any reason by my insurance company.

Signed Date

Print Name