CONNECTICUT LABORERS' HEALTH FUND

435 Captain Thomas Boulevard
West Haven, CT 06516
(203) 934-7991 (800) 922-3240
Fax Number: (203) 680-3847

MASSAGE THERAPY CLAIM FORM

MEMBER'S NAME (Please Print): _____

SOCIAL SECURITY # (last 4 digits): _____

MEMBER'S HOME ADDRESS: _____
Check here ❒ if this is a new address and include a copy of your driver's license.

MEMBER'S PHONE NO.: _____ (Please check here ❒ if this is your cell number.

MEMBER'S EMAIL ADDRESS: _____

Procedure Code	**Name of Member or Dependent (Please print)**	**Date of Service**	**Charge**
97124	_____	_____	_____
97124	_____	_____	_____
97124	_____	_____	_____
97124	_____	_____	_____

Please attach an itemized statement from a licensed massage therapist, including the patient's name, therapist's complete name, address, phone number, license number and return it with this completed Claim Form to the Fund Office.

Completion of this form is not a guarantee of payment. All claims are subject to review of the service submitted and requires that the patient is a covered participant at the time of service.
By signing this Claim Form I am certifying that the statements contained within this claim form are accurate to the best of my knowledge and belief. I understand I am responsible for charges not covered by the Health Fund.

Member's Signature: _____ Date: _____