Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Massage Therapy Reimbursement

The massage benefit will reimburse paid fees up to $50 per massage ($1,650 annual max). Reimbursement for massage therapy is available for the member and covered spouses only. Proof of paid services must be included with the completed/signed form. Failure to provide a copy of receipt will result in a denied claim.

SECTION 1: MEMBER INFORMATION

Member's Full Name	Date of Birth	SSN (last 4 digits)	
Mailing Address	City	State	Zip Code
Primary Phone	E-mail Address		

SECTION 2: CLAIMANT INFORMATION

❐ **Check box if Claimant is the member, then skip to Section 3**

Claimant's Full Name	SSN (last 4 digits)		
Mailing Address (if different)	City	State	Zip Code
Prime Phone	E-mail Address		

SECTION 3: ITEMIZED CLAIM DETAIL (Proof of paid services MUST be included for each date listed)

Date of Service	Description of Service	Provider Charge

SECTION 4: PROVIDER INFORMATION (to be completed by licensed massage therapist)

Therapist's Full Name	Daytime Phone Number		
Facility or Spa Name (if applicable)	License #		
Mailing Address	City	State	Zip Code

I certify that I am a licensed therapist and have provided the services(s) on the date(s) outlined in Section 3.

Therapist's Signature: **Date:**

SECTION 5: CERTIFICATION & AUTHORIZATION

I certify that the information provided on this form is complete and accurate. I authorize the provider to release any information to Allegiant Care that would be necessary to process this claim. I understand the reimbursement will be made directly to the member listed in Section 1.

Claimant Signature: ______________________________ **Date:** ____________

Completed documents may be mailed to the address above or faxed to 603-792-7214
or uploaded at www.myallegiantcare.com/send
Retain a copy of this form for your records.