Holistic Healthcare Services, Inc.

Phone: (413) 323-4773

Insurance Verification Form

Please fill in the first box with your personal information. Then fill in box 2, 3, or 4 depending on the type of insurance claim.

Box #1: For all insurance claims

Your Name: ______________________________ Date of Birth: ___________________

Address: _________________________________ Home phone: ___________________

_________________________________ Work phone: ___________________

Box #2: For Workers Comp Claims only

Employer Name: _____________________________________ Employer Phone: ___________________

Employer Address: ___________________________________ Date of injury: ____________________

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Insurance Company: _________________________________ Insurance phone: ___________________

Insurance Address: _________________________________ Claim #: _________________________

_________________________________ Contact Person: ___________________

Box #3: For Auto Accident (PIP) Claims only

Insurance Name: ___________________________________ Contact Person: ____________________

Insurance Address: _________________________________ Insurance Phone : __________________

_________________________________ Date of Accident: ___________________

Claim #: ________________________ Attorney Name: _______________________________________

Attorney Address: _____________________________________

Attorney Phone: ___________________ _____________________________________

Note: Please fill in Box # 4 as well

Holistic Heathcare Services, Inc. * 21 Everett Avenue * Belchertown, MA 01007 * (413) 323-4773

At The Pain Management Program * Baystate Medical Center * 3400 North Main Street * Springfield, MA 01199 * (413) 794-4681

Box #4: For all other Health Insurance Claims

Name of Insured: ________________________________ Insured Phone: __________________

Address of Insured: ______________________________ Date of Birth of Insured: ___________

______________________________ Relationship to Insured: __ Spouse
__ Child

Insurance Name: ________________________________ Insurance Phone: ________________

Insurance Address: ______________________________ Policy or ID #: _________________

______________________________ Group #: ______________________

Deductible amount: _____________________________ Co-pay amount: ________________

FOR OFFICE USE ONLY:

Diagnosis Code(s) ____

Acupuncture Coverage: ____

Date of confirmation of coverage: ____

Name of person contacted: __________________________________ Office personnel initials: ______

Limit to # of treatments? ________________ Deductible:______________________________

Limit to diagnosis? _________________ Co-pay/coinsurance: ______________________

Must provider be an MD? _______________

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