NEW ENGLAND PASTORAL INSTITUTE, INC.

5 Summer Street
Lynnfield, MA 01940
603-890-6767

15 Ermer Road, Suite 215
Salem, NH 03079
603-890-6767
FAX 603-893-6767

20 West Park Street, Suite 214
Lebanon, NH 03766
603-448-2414

The following information is needed to process your insurance claims for your services provided by NEPI. It is your responsibility to provide complete and accurate information so that claims can be submitted in a timely manner. Please print clearly.

CLIENT INFORMATION:

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Social Security # _____-_____-_____

Work Phone _____ Birth Date _____/_____/_____

Fax _____ Mobile Phone _____ Sex ☐ Male ☐ Female

Email _____ Other Phone _____

Patient Status ☐ single ☐ married ☐ other Referring Physician _____

☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Is Patient's Condition Related to

☐ Employment?

☐ Auto Accident? State _____

☐ Other Accident?

Hospitalization Dates

From _____/_____/_____ To _____/_____/_____

RESPONSIBLE PARTY: **Check here if Responsible Party is same as Client** ☐

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Social Security # _____-_____-_____

Work Phone _____ Birth Date _____/_____/_____

Fax _____ Mobile Phone _____ Sex ☐ Male ☐ Female

Email _____ Other Phone _____

PRIMARY INSURANCE COMPANY:

☐ Medicaid ☐ Group ☐ HMO ☐ PPO ☐ Other _____

Insured's I.D. Number _____ Social Security # _____-_____-_____

Insurance Company _____

Claims Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Contact Person _____

Insured's Name (Last, First, Middle) _____

Please continue to second page/other side

Client Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address _____

City _____ State _____ Zip Code _____

Telephone; Home _____ Work _____ FAX _____

Mobile _____ Email _____

Insured's Policy Group FECA Number _____

Date of Birth _____/_____/_____ Sex ☐ Male ☐ Female

Employer's or School's Name _____

Insurance Plan Name _____ ☐ Is there another health plan?

_____ _____

Client's Signature (Parent/Guardian if client is a minor) Date

_____ _____

Responsible Party's Signature Date

_____ _____

Insured's Signature Date