BAYSTATE BENEFIT SERVICES
SERVICE/CLAIM INFORMATION FORM

In order to provide assistance, we will need to know the specifics of your situation. Please describe the problem by including copies of the bills, explanations of benefits (EOB's), doctor or facility name(s), etc. Please let us know if you have spoken to the insurance company or the provider, and if so, what information they have provided. We will attempt to resolve all issues favorably and in a timely manner.

Employer's Name _____

Insurance Carrier _____

Group # _____

Employee's Name _____

Subscriber ID# (all digits) _____

Last 4 digits of Employee's SS# _____

Employee's Date of Birth _____

Patient's Name _____

Patient's ID# _____

Patient's Date of Birth _____

PLEASE FAX INFORMATION TO BAYSTATE BENEFIT SERVICES AT 781-356-7365. FOR INQUIRIES AND QUESTIONS, PLEASE CONTACT:

DONNA MAKI
SERVICE COORDINATOR

TELEPHONE #: 800-601-3570 EXT. 212
E-MAIL: dmaki@baystatebenefits.com

Baystate Benefit Services should reply to:

NAME: _____

TELPHONE #: _____

E-MAIL: _____