***Pyramid Nutrition Services, Inc***

**Health Benefit Affidavit**

**33 Mulberry Street 14 South Westfield St 77 Mill St., Ste 233 Phone: (413) 330-8167**

**Springfield, MA 01105 Feeding Hills, MA 01030 Westfield, MA 01085 Fax: (413) 480-0517**

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**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) I do NOT have medical insurance.**

**I certify that I do not have any personal insurance coverage at this time.**

**Signed under the pains and penalties of perjury this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature Witness’s Signature**

**( ) I DO have medical insurance.**

**Health Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Insurance Company’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Name (If Other Than Self):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship To Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Employer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Employer Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) I have MassHealth**

**( ) I have Medicare A & B.**

**Copy of Insurance Card (front & back) Attached: ( ) Yes ( ) No**

**Copy of Patient’s Identification Attached: ( ) Yes ( ) No**

**I authorize Pyramid Nutrition Services to furnish my insurance company with information necessary for the above named patient.**

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**Patient’s Signature Date**