

Innovative Pain Solutions

Phone: (937) 323-3900 – Toll Free: (866) 403-3870 – Fax: (937) 323-4039

2816 W. First St., Springfield, OH 45504

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Insurance Information:

Primary: _____ Secondary: _____

Member Name (if different from patient): _____

Relationship to the patient: _____

Member's Date of Birth: _____ Social Security Number: _____

(United Healthcare with out-of-network benefits only)

Precertification required: No Yes (Include person's name from insurance company, date, and authorization number) _____

Worker' Compensation: No Yes (Must have authorized C9)

Reason for Referral/Diagnosis: _____

Referring Physician: _____ NPI#: _____

Contact Name: _____

Office Phone #: _____ Fax #: _____

Our office will fill out the Appointment below and fax back to you via a secure fax line. Thank you for filling out this form completely. This will help optimize your patient's visit.

Appointment Date: _____ Time: _____ am pm

Important: Please fax this completed form with the medical records, test results (i.e. MRI, X-ray, or EMG results) and medication history . Also, please include a copy of the patient's current insurance cards (front and back).