

BILLING AUTHORIZATION

Client Name: _____ Sex: M F
(Last) (First) (Middle Initial)

Address: _____

County of Origin: _____ County of Residence: _____

Home Phone (_____) _____ Business Phone (_____) _____

Date of Birth: _____ Age: _____ SS#: _____

Employer: _____

Guardian's Name: _____

Address: _____

Who Referred You: _____

Monthly Household Income: _____

Family Size: _____ List Family Members: _____

INSURANCE INFORMATION

Answer each item completely and provide a completed claim form at your earliest convenience. A copy of your Medicaid Card must be furnished monthly.

Medicaid/Medicare Number: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Address: _____ SS#: _____

Subscriber's Employer: _____

Group Name/Number: _____ Subscriber ID: _____

Responsible Party's Name & Address: _____

(Our office will bill your insurance carrier directly for all services unless other arrangements have been made. The responsible party will also receive a bill and is responsible for any unpaid balance. Client's or responsible party's signature authorizes release of information as may be necessary to the insurance carrier for processing of insurance claims. Signature also authorizes payment of insurance benefits to be made directly to the supplier of the services.)

Notice to Medicaid Clients: Ohio has mandated limits to the total number of mental health services that Medicaid will pay for per fiscal year (July 1-June 30th). If you see multiple providers each service is deducted from the total amount of services allowed each year. If you go over your total number of services allowed you are financially responsible for the services that are denied by Medicaid. Please see the Client Guidelines for a list of the limits on each type of service.

Signed _____ Date _____

Print Name: _____