CALIFORNIA BILLABLES PROJECT

Registration Forms for Billing

1. Assignment of Benefits

- I authorize release of information to all my insurance companies
- I permit a copy of this authorization to be used in place of the original.
- I authorize and assign the health insurance benefits to which I am entitled (including any checks I may receive directly from insurance) to my Care Provider for their services.
- I authorize my Care Provider to release all information necessary to secure the payment of benefits.
- I understand that my Care Provider may submit insurance claims as a courtesy to me; however, in some cases exact insurance benefits cannot be determined until the insurance company receives my claim. In the event that the service is not covered, **I am aware that I am financially responsible for any and all services provided to me.** This will also include any pillows, cushions, nutritional supplements, or any other durable medical equipment supplied to me, or my minor.
- Upon a 30-day default this account may be placed with our collections agency.
- I have signed this authorization in my Care Provider's office on the date below.

Name ______________________

Signature ______________________ Date ____________

An agreement between three parties—the patient, the insurer, and the health care provider—which allows the insurer to transfer the patient's insurance benefits directly to the health care provider.

The patient gives the insurer permission to send payment for services directly to the medical provider. In order for the agreement to be valid and legally binding, all three parties must give consent.

2. Financial Disclosure

☐ **I understand that charges are based on an established fee policy and discounted using the disclosed income stated below.**

Or

☐ **I do not wish to disclose our family income. I understand that I will be responsible for all charges.**

[*This option means the patient is responsible for costs and not eligible for income-based financial assistance.]*

The financial disclosure form documents a patient's income, if they wish to be considered for financial assistance.
Some patients don't wish to disclose this information. The form should give the patient *two options* to choose from.

3. Insurance Verification (see sample page 2)

Used to verify a patient's insurance benefits by phone.
In addition to insurance status information, the form has fields to note the insurance rep's name or badge #, the date you spoke, and a tracking number for the conversation.

SAMPLE COUNTY PUBLIC HEALTH SERVICES DEPARTMENT

INSURANCE INFORMATION AND VERIFICATION

Patient Label Name: DOB: Patient #:	Routine Vaccines ❑ Overseas/Travel Vaccines ❑ Other Clinic Services ❑

Mark [X] the type of Insurance the patient has

AETNA		**KERN HEALTH SYSTEMS**	
ANTHEM BLUE CROSS		**MANAGED CARE SYSTEMS (MCS)**	
BFMC - - Bakersfield Family Medical Center		**MEDICARE**	
BLUE CROSS		**OUT OF COUNTY MEDI-CAL**	
BLUE CROSS ANTHEM – SISC III		**PINNACLE**	
BLUE SHIELD		**STRAIGHT MEDI-CAL**	
CIGNA		**TRI-CARE**	
DELTA HEALTH BLUE CROSS PPO		**UNITED AGRI BEN TRUST**	
GEMCARE HMO		**UNITED HEALTH CARE**	
HEALTH NET - - Medi-Cal		**WESTERN GROWER'S**	
HEALTH NET - - Independence Medical Group		**OTHER** (write in):	
HUMANA		**OTHER** (write in):	
KAISER			
KERN FAMILY HEALTH CARE		Type of plan HMO ❑ PPO ❑	

INSURANCE VERIFICATION

We are an In-Network ❑ Out-of-Network ❑ provider.	Tax ID: 956000925
Clinic NPI # 1023167541	LAB NPI# 1636065556
Are lab services a covered benefit? YES ❑ NO ❑	What percentage? ___________ %
Do you cover preventive (or) medical services?	Preventive ❑ Medical Service ❑
What percentage is covered? _________________%	Is there a co-insurance amount? $______________________
Does the patient have a deductible? YES ❑ NO ❑	What is the deductible? $______________________
Has the deductible been met? YES ❑ NO ❑	Is there any co-payment amount? $____________________
Where do I submit the claims?	
Insurance Company Representative Name:____	Date of Call:______________ Time of Call:_____________
Reference Number _______________________________	Insurance Verifiers Name: ________________________

VACCINE ELIGIBILITY

CLIENT HAS HEALTH INSURANCE BUT:	Insurance does not cover any vaccine ❑ Insurance only covers some vaccine ❑ What is covered: ________________________________
CLIENT DOES NOT HAVE INSURANCE COVERAGE:	Client applied for CHDP ❑ Client did **not** want to apply for CHDP ❑ Client applied for Family PACT ❑ Client did **not** want to apply for Family PACT ❑