Especially Births Medical Billing Service

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Website: www.EspeciallyBirths.com

Highland Midwife Birth Services

New Patient Information

☐ Update of a form already on file for this pregnancy.

Health Provider: Lorri Carr, *LM CPM* Date: _____ Initial Visit: _____

Patient Name, First:	Middle:	Last:
Date of Birth:	Age:	SSN:
Mailing Address, Street:		
City, State, Zip:		Home Phone:
Email:		Other Phone:
Drivers License Number & State Issued: Attach copy of card.		*Last Menstrual Period / Estimated Due Date*
Partner Name:	Date of Birth:	Marital Status:
Primary Insurance Company: Attach copy of both sides of card.		Plan:
Subscriber Name:		Date of Birth:
ID Number:		Group Number & Name:
Secondary Insur. Company: Attach copy of both sides of card.		Plan:
Subscriber Name:		Date of Birth:
ID Number:		Group Number & Name:
Medicaid Billing: ☐ WA ☐ OR ProviderOne or OHP ID Number: Attach copy of both sides of card.		

Eligibility and benefit information will be sent to your health provider.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the provider that accepts assignment below. I authorize payment of medical benefits to the undersigned Health Provider for services rendered. I understand that medical eligibility and benefits are subject to terms and conditions of the health insurance policy at the time services are rendered. A quote of benefits is not a guarantee of coverage. Medical benefits are a contractual agreement between the Patient and the Insurance Carrier. It is the responsibility of the patient to notify the Health Provider and Especially Births Billing Service of any changes to their insurance coverage. The Insurance Carrier will not notify the Health Provider of changes to eligibility or benefits. In order to receive timely statements, the patient must notify Especially Births Medical Billing Service of any changes to the patient's mailing address.

Patient Signature: _____ Date: _____

Health Provider Accepting Payment Assignment: Date: