

Especially Births Medical Billing Service

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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.		<i>Last Menstrual Period / Estimated Due Date</i>
Partner Name: _____ Date of Birth: _____ Marital Status: _____		
Primary Insurance Company: _____ Plan: _____ Attach copy of both sides of card.		
Subscriber Name: _____		Date of Birth: _____
ID Number: _____	Group Number & Name: _____	
Secondary Insur. Company: _____ Plan: _____ Attach copy of both sides of card.		
Subscriber Name: _____		Date of Birth: _____
ID Number: _____	Group Number & Name: _____	
Medicaid Billing: <input type="checkbox"/> WA <input type="checkbox"/> 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: _____