Signature on File My Testing CMHC-DH4 CONFIDENTIAL-DRAFT	Case Name: Case Id#: Date:

A

Recipient's Name:
Insurance ID#:

I request that payment of authorized insurance benefits be made on my behalf, to My Testing CMHC-DH4. I authorize any holder of medical information about me to release to the third party payer and its agents any information needed to determine these benefits, or the benefits payable for related services.

All therapists of My Testing CMHC-DH4 are qualified Master's Level therapists who meet or exceed the credentialing standards set by The Mississippi State Department of Mental Health. Some insurance companies, however, require a special license before the company will reimburse for services rendered to clients. Therefore, your insurance carrier may not pay for the service My Testing CMHC-DH4 provides. Non-therapy providers at My Testing CMHC-DH4 also provide day treatment and community support services; your insurance carrier may not pay for these services. Your signature below indicates that your have been informed of this and you accept the responsibility for payment of non-covered services.

B

Medicaid I.D. Number:

I request payment of authorized Medicaid benefits be made on my behalf to My Testing CMHC-DH4. I authorize any holder of medical or other information about me to release to the Division of Medicaid or the fiscal agent any information needed to determine these benefits of the benefits payable for related services.

C

Medicare I.D. Number

I request payment of authorized Medicare benefits be made on my behalf to My Testing CMHC-DH4. I authorized any holder of medical or other information about me to release to the Division of Medicare or the fiscal agent any information needed to determine these benefits payable for related services.

~ This Authorization is Good for one year ~
(or updated if any of the above changes)

My signature below give My Testing CMHC-DH4 consent to bill or retroactively bill for all covered services within the signature date and the release of any medical records information needed to determine payment for these services by any of my payer sources.

_____ _____

Forms All Preview
Recipient's Signature

Date

When the authorization is obtained, the provider should indicate "SIGNATURE ON FILE" in the patient's signature space on the claim form.

If you are submitting a signed claim form or if you are maintaining signature on file, the recipient's signature requirement remains the same. Be sure the recipient signs his/her name. If the recipient cannot write his/her name, he/she should sign by a mark and have a witness sign the recipient's name and indicate by whom the name was entered. If the recipient is a minor or otherwise unable to sign, any responsible person, such as a parent or guardian,

must enter the recipient's name and write "By", sign his/her own name and address in the space, show his/her relationship to the recipient and explain briefly why the recipient cannot sign.