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| **Client Registration Form (CRF)**  *Providers: Please send this form to your biller at the beginning of care with your client. This is step one in the billing process. In order to submit a test claim, please complete the Test Claim Superbill and send it to your assigned biller for processing.*  **Provider Name and Credentials: Mercy Eizenga, LM, CPM** |

**CLIENT INFORMATION** \*Please provide your e-mail address if you would like to receive a copy of your completed benefits.

Name (Last, First, MI)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Home Phone(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: 🞏single 🞏married 🞏widowed 🞏separated 🞏divorced Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due Date\_\_\_\_\_\_\_\_\_\_\_\_\_ LMP \_\_\_\_\_\_\_\_\_\_\_\_\_ First Pregnancy? □Yes □No

Planning home or birth center birth? 🞏Home 🞏Birth center (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION** 🞏 Insurance Only 🞏 LBS Pay Plan Only 🞏 BOTH Insurance and LBS Pay Plan

**Primary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Plan Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Insurance Phone# (for providers)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Electronic Payor ID# (5 digits)\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏Male 🞏Female Subscriber’s Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID# on Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client’s Relationship to Subscriber: 🞏Self 🞏Spouse 🞏Child 🞏Other

**Secondary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Plan Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Insurance Phone# (for providers)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Electronic Payor ID# (5 digits)\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber’s Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID# on Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client’s Relationship to Subscriber: 🞏Self 🞏Spouse 🞏Child 🞏Other

Notes/instructions regarding this CRF:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I certify that the information on this form is correct to the best of my knowledge. I authorize Larsen Billing Service to verify my insurance benefits on my behalf for the fee of **$15**, which I will pay one of two ways as indicated below. I hereby authorize my insurance company to make payment directly to my provider should claims be filed. I give authorization to my provider to release any information necessary to process my benefits or insurance claims. I understand the final outcome for my insurance benefits level and the processing of my claims is under the discretion of the insurance company. I will not hold Larsen Billing Service or my midwife responsible for the information reported on this verification or the manner in which my claims process.

**Signature of Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Initials: \_\_\_\_\_\_\_\_\_\_** In some cases insurance claims may deny and require an appeal process. In this circumstance, I authorize Larsen Billing Service (LBS) to pursue appeals on my behalf. I understand this will be at the discretion of LBS and there is no additional charge for this service. I also understand that it may be necessary for LBS to contact me via e-mail or by telephone if appeals are pursued. (\*Please provide your e-mail address in the top portion of this form.)

**Please select one payment option below:**

🞏 I will pay $15.00 online through the LBS website at [www.larsenbilling.com](http://www.larsenbilling.com)

🞏 I will pay $15.00 to my provider/midwife