



LARSEN BILLING SERVICE

Please send this form to your LBS account representative. To find your rep's e-mail or fax number please visit our web-site at www.larsenbilling.com

Client Registration Form (CRF)

Providers: please send this form to your biller at the very start of care with your client. This is step one in the billing process.

Open Arms Midwifery, LLC: _____
Deborah Healy, LM, CNM

Provider's office must complete this box, unless a superbill will accompany this CRF when you submit to LBS:

For test claim, bill Initial OB exam (check ONE box):

Providers: in the event an initial exam has not been completed when first sending this CRF, please e-mail this info to your biller once the care occurs.

99205 (60 min-10 body systems-complete medical history-high decision making)

99204 (45 min-10 body systems-complete medical history-moderate decision making)

99203 (30 min-6 body systems-pertinent medical history-low decision making)

This is a returning established patient that I have provided care for in the past 3 yrs. Details regarding visit: _____

Date of service: _____ **Comments:** _____

CLIENT INFORMATION

Name (Last, First, MI) _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone(____) _____ Alternate 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

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: _____

I certify that the information on this form is correct to the best of my knowledge. I hereby authorize my insurance company to make payment directly to my provider. I also give authorization to my provider to release any information necessary to process my insurance claims. I authorize Larsen Billing Service to verify my insurance benefits on my behalf for the fee of \$15. I understand the final outcome for the processing of my claims is under the discretion of the insurance company and I will not hold Larsen Billing Service or my midwife responsible for the way in which my claims process.

Signature of Client: _____ **Date:** _____