# LARSEN BILLING SERVICE

Please submit this completed form to Larsen Billing Service. Fax: 360.825.1855 Email: info@larsenbilling.com

## Client Registration Form (CRF)

*Client: Please fill in this form entirely and submit it to LBS through our website or through your provider's office.*

**Provider Name and Credentials:** ________________________________________________

**Facility Name:** ____________________ **or Business Name:** ______________________ **(if applicable)**

### 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:_______________________________________________________________

_____________________________________________________________________________________________

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 <u>one</u> payment option below:**

☐ I will pay $15.00 online through the LBS website at www.larsenbilling.com

☐ I will pay $15.00 to my provider/midwife