LARSEN BILLING SERVICE

Send form to LBS rep: Maile Mudaliar 39280 Cascadia Village Dr., Sandy, OR 97055 Toll-free phone: (866) 208-8269
Fax – (503) 826-9284 E-mail – maile.mudaliar@larsenbilling.com

Client Registration Form (CRF)

Home Birth Midwifery Service

Kimberley Mosny, CPM, LM

Provider's office must complete this box, unless a superbill will accompany this CRF when you submit to LBS:
For test claim, bill: ☐Pregnancy confirmation visit (if before 20 weeks): ☐straightforward ☐detailed
☐Initial OB visit (for late transfers): ☐straightforward ☐detailed ☐complex ☐comprehensive
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

INSURANCE INFORMATION

Primary 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

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 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.

Signature of Client:____ Date: ______________________

☐ I choose to hire Larsen Billing Service to verify my benefits, obtain authorizations as needed, and attempt in-network exceptions. I understand that my midwife will be billed $15 for this service; I will pay my midwife for this fee *(please do not send checks directly to Larsen Billing Service).*

☐ I choose to verify benefits myself. I understand that I must submit a completed Verification of Benefits form to my midwife as soon as possible in order for Larsen Billing Service to bill claims on my behalf. If I obtain incorrect benefits information, I will not hold Larsen Billing Service or my midwife responsible for the way in which my claims process. If I have trouble with the verification, authorization, or exception processes, I understand that I may choose to hire Larsen Billing Service at a later date for the fee of $15.

Updated: 1/5/09