**INSURANCE BILLING AUTHORIZATION FORM**

This form authorizes GRACE HEALTH SERVICES LLC to use or disclose your patient health information to bill Medicare, Medicaid, CCS, or your private insurance company for evaluation and treatment of your medical/psychiatric conditions.

I request that payment of authorized Medicare, Medicaid, and/or other insurance benefits be made on my behalf to GRACE HEALTH SERVICES LLC for services provided me by GRACE HEALTH SERVICES LLC, its agents, and employees. I authorize any holder of medical information about me to release to GRACE HEALTH SERVICES LLC, Medicare, Medicaid, CCS, and/or any other insurance company including its agents and employees, any information or documentation needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to secure payment for the claim. If I have supplemental health insurance coverage, my signature authorizes releasing the medical information to the supplemental insurance company, its agents, and employees. This signature authorization shall remain in effect until revoked by me in writing.

I understand that GRACE HEALTH SERVICES LLC is HIPPA compliant and I have the right to request a copy of GRACE HEALTH SERVICES LLC’s Privacy Notice and to review it before signing this authorization form. A photocopy of this authorization is to be considered as valid as an original.

**BILLING YOUR INSURANCE DOES NOT GUARANTEE PAYMENT. THE AMOUNT PAID BY INSURANCE CANNOT BE GUARANTEED. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR BALANCE.**

Patient’s Name (PRINT):

Patient’s Signature:

Date:

**Primary Insurance:**

Subscriber’s Name (if other than patient):

Subscriber’s Date of Birth: / /

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance:**

Subscriber’s Name (if other than patient):

Subscriber’s Date of Birth: / /

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PPO/HMO  [circle one] Referred by:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Required for Medicare /HMO Provider phone number [on back of card] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you can send a copy of front and back of your insurance card