Client Registration for Insurance Benefits
Birth Matters! Midwifery Services
Dorothy Kirkpatrick, RM, CPM

☐ Check here if you want LBS to verify your benefits (there will be a $15 fee)

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 __________

Date of initial exam (not interview):_________________ First pregnancy? ☐Yes ☐No

INSURANCE INFORMATION

Primary Insurance__________________________Plan Name____________Effective____________

Ins. Address________________________City, State, Zip________________Ins. Phone___________

Subscriber Name_______________________Subscriber's DOB________Subscriber's SS#____________

ID# on Card_____________________Group #___________________Electronic payor ID#_________

Client's relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance________________________Plan Name____________Effective____________

Ins. Address________________________City, State, Zip________________Ins. Phone___________

Subscriber Name_______________________Subscriber's DOB________Subscriber's SS#____________

ID# on Card_____________________Group #___________________Electronic payor ID#_________

Client's relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

***Verification of Benefits: *Please call your insurance company and ask the following questions.**-OR-**Check the box at the top of this form to have Larsen Billing call and verify your benefits. There will be a $15 fee for LBS to call.*

Name of insurance rep spoken to__________________________ Date_______________ Time________

What is my eligibility date?_____________ What is my out-of-network deductible?_______________How much of my deductible do I still need to meet?__________Is this an HMO Plan?_________Is a registered midwife covered by my plan?________ Do I need a referral or authorization for maternity care or newborn care?_________ (Number to call if yes)_______________________(call and get auth#) __________________What percentage of the Usual and Customary will be paid for maternity care (CPT code 59400)? __________(The remaining ______% is my responsibility.) When does my baby need to be added to the plan?__________Is baby's deductible included in mine?_________If not, how much is baby's deductible? _____ Will insurance reimbursement be sent to the provider or to me?__________Is pregnancy a pre-existing condition? ____________________ If I want an in-network exception (because there are no contracted midwives in my area), what number do I call? ______

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Comments____

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Send this form to: Cheri White ~ 3188 W Shayla Dr ~ West Jordan, UT 84088 ~ Toll-free phone (866) 673-2078 ~ Fax (801) 562-8860