



PROVIDER INFORMATION FORM

Please return this form to Diane Harston by fax at 360.825.1855 or e-mail at Diane.Harston@larsenbilling.com.

PROVIDER/EMPLOYEE INFORMATION: Owner Partner Employee Not applicable

Provider Name (no nicknames): _____

Credentials: _____ License Number: _____ Date of Birth: _____

BILLING PREFERENCE:

Tell us how you would like Larsen Billing Service to represent you and your practice. Your choice determines how your account will be set up for reimbursements from the insurance companies. Note: Larsen Billing Service is not in a position to give advice concerning this matter and suggests you counsel with a CPA or Accountant for direction if necessary.

If you do not have a birth center (billing professional fees only):

- My name using my social security number My name & my business name using my social security number
 My name and my business name using business Employee Identification Number (EIN)

Note: Each of these options will be set up using your name as the business name. If you want your account to be set up using your Business Name, please indicate this choice by checking the box below:

- Yes, please use my business name when setting up my account

If you have a birth center:

- My name using my social security number My name & my business name using my social security number
 My business name using EIN (for when you want everything to run through the birth center and you take your professional fees out from there)

Note: We cannot bill for facility claims using a social security number. All facility claims are to be billed using an Employer Identification Number (EIN).

If you want to set up for reimbursements on both professional and facility services:

Note: This option is treated as two separate accounts, and each will be billed a separate set-up fee

- My name using my social security number and Business name using EIN

TAX IDENTIFICATION / NPI:

Individual Tax Identification Number: _____ SSN EIN

Group Tax Identification Number (EIN): _____

Individual NPI #: _____ Group/Business NPI#: _____

Do you have a CLIA waiver? Y N #: _____ Must send copy to LBS or we cannot bill labs.

CONTACT INFORMATION:

Mailing Address (where you want your checks sent): _____

City: _____ County: _____ State: _____ ZIP: _____

Physical Address (if your mailing address is a PO Box): _____

City: _____ County: _____ State: _____ ZIP: _____

Best phone # to reach you: _____ Alternate phone #: _____

Fax number: _____ Do we need to call before faxing? Yes No

Email address: _____ Website: _____

NAME: _____

BUSINESS NAME / BIRTHING CENTER:

Business Name (if applicable): _____

Is this a Birthing Center?: Yes No If yes, License Number: _____

Type of Practice: Individual Group Notes: _____

HISTORY WITH INSURANCE COMPANIES:

Have you billed insurance companies before? Yes No

BC/BS PIN: _____ Medicaid PIN: _____ Other: _____

Major companies billed previously: Aetna Cigna UHC BC/BS Medicaid Tricare (CNMs only)

Are you registered for any online claim access information (ex: Navinet, Availity) Yes No

If yes, which companies? _____

Do any insurance companies have you in their system with outdated demographics information? Yes No

If yes, you must complete Previous Demographic Information Form. Please send me a Demographics Information Form.

Fax to: _____ Email to: _____

BILLING INFORMATION:

Average number of births per year (insurance): _____

How much should we bill insurance for the global fee (code 59400)? \$ _____

Are you willing to have us set you up for electronic EOBs (ERAs)? Yes No

For birth centers **only**: How much should we bill insurance for your facility fees for mom/baby? \$ _____/\$ _____

PARTNER/EMPLOYEE INFORMATION: (IF APPLICABLE)

Partner Employee Independent Contractor N/A

(Note: Another provider can be added to this application if you share the same business name, address, and group tax ID#. If you do not share the same tax ID, the provider will need to fill out a separate application and pay a set-up fee.)

Provider Name (no nicknames please): _____

Credentials: _____ License Number: _____ Date of Birth: _____

Best phone # to reach partner: _____ Alternate phone #: _____

Fax number: _____ Do we need to call before faxing? Yes No

Email address: _____ Website: _____

Individual NPI #: _____

Does your partner have a CLIA waiver? Y N #: _____ Billed insurance before? Yes No

BC/BS PIN: _____ Medicaid PIN: _____ Other: _____

Major companies billed previously: Aetna Cigna UHC BC/BS Medicaid Tricare (CNMs only)

Do any insurance companies have your partner in their system with outdated demographics information?

Yes No If yes, your partner must complete Previous Demographic Information Form.

NAME: _____

ADDITIONAL CLAIMS ACCESS:

Are there others from your practice you would like to allow *viewing access* to our server for viewing the status of your claims? (Example: office assistant, birth assistant, etc.) Yes No

If yes, please list first and last name(s): _____

CLIENT BILLING:

Have you been informed about the LBS Client Billing Program (cash pay)? Yes No

Are you interested in enrolling in our Client Billing Program? Yes No

Would you like information about the Client Billing Program? Yes No

OTHER:

How would you like LBS to send your invoices to you? By mail By e-mail

Is your computer a Mac? Yes No

NOTES:

Names & phone #s of your associates who will be in contact with us: _____

How did you hear about us? _____

Additional information you would like us to know: _____

Important Note: We will use this information exactly how it appears on this form to send claims to the insurance companies and to contact you. Incorrect information could result in delayed payments and other problems or confusion. Please confirm that all information is accurate. Once the information has been entered into our system there will be a \$200 fee for any major information changes to your account. These include: Provider Name, Business Name, Credentials, Mailing Address, Individual Tax Identification Number/EIN, Group Tax Identification Number/EIN, and NPI Number. There will be no fee to change your email address or phone/fax number.

****By signing below I acknowledge that I have read the notice and am aware of the additional fees for major changes to my account.**

Signature: _____ **Date:** _____

Print Name: _____

Signature: _____ **Date:** _____

Print Name: _____

For questions regarding this form, please contact Diane Harston at (253) 261-8878 or
diane.harston@larsenbilling.com