



# 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 one payment option below:

I will pay \$15.00 online through the LBS website at [www.larsenbilling.com](http://www.larsenbilling.com)

I will pay \$15.00 to my provider/midwife