Client Registration for Insurance Benefits

Blessed Beginnings, Inc.
Edythe Wells, CPM, LM

☒ 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 _________ First pregnancy? ☐Yes ☐No

Date of pregnancy confirmation visit:________________ (straightforward / detailed / complex / comprehensive)

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 Licensed 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?________________________Comments___________________________________

_____________________Name of person completing this form:______________________________

Please make a copy of this form for your midwife, and mail or fax to:

LBS Rep: Andrea Tallman, 2905 Bluebonnet Drive, Killeen, TX 76549 ~ Fax: 254-220-4863

Any Q's, please call Andrea toll free at (866) 462-3334

Or just give the form to Edie, and she will send it on to LBS