LAKE COUNTY HEALTH DEPARTMENT and COMMUNITY HEALTH CENTER
Behavioral Health Services
INSURANCE COVERAGE FORM

Encounter/PAL Label

INSURANCE COVERAGE

Insurance Company: _____ Phone Number: _____
(Primary / Secondary)
Claim Address: _____ Group/Policy #: _____
_____ ID #: _____
Policyholder (Employer Name): _____ Effective Dates: _____
Employee Name: _____

Insurance Company: _____ Phone Number: _____
(Primary / Secondary)
Claim Address: _____ Group/Policy #: _____
_____ ID #: _____
Policyholder (Employer Name): _____ Effective Dates: _____
Employee Name: _____

MEDICAID COVERAGE

Case ID # _____ Recipient #

_____

MEDICARE COVERAGE (Primary / Secondary)

Beneficiary Name: _____
HIC # (Medicare Number): _____ Effective Dates: _____

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment (Lake County Health Department).

SIGNATURE: _____ DATE: _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medial benefits to the undersigned physician or suppliers for service provided (Lake County Health Department).

SIGNATURE: _____ DATE: _____

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE

I hereby certify the statements of this form are complete and accurate to the best of my knowledge and agree to pay the assessed fee for each service provided.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

INCOME VERIFICATION REQUIRED

SCAN COPIES OF CARDS INTO NEXTGEN OR ATTACH COPIES IF SCANNER IS UNAVAILABLE