Child & Family Agency of Southeastern Connecticut, Inc.

RELEASE OF HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS

The following form requests information about your insurance. Please have your insurance information ready to fill out this form.

Does the person receiving services have Medicaid/HUSKY Insurance? **If yes, please fill out the information below.**

- o Yes
- o No

***Medicaid #*:**____________________

Child's Name on card: ____

Does the person receiving services student have Private/Commercial Insurance? **If yes, please fill out information below.**

- o Yes
- o No

Policy Holder Name*

First __________________________ **Last**____________________

*Policy Holder Date of Birth** ____________

mm/dd/yyyy

Name of Medical Insurance* ________________________

Member ID #*

Group Number _____________________________

Secondary Insurance Phone # _______________________

On back of card

Policy Holder's Employer* ____

Address *(If different from above)*

____

Street Address

____

Address Line 2 (PO Box, Apartment #, etc)

_______________________________________ _____________________________________

City *State*

____

ZIP Code

Insurance Phone # ___________________

On back of card

Is there secondary insurance? *

O *Yes*

O *No*

Secondary Policy Holder Name*

First ___________________________ **Last**_____________________

Secondary Policy Holder Date of Birth* _________________________

mm/dd/yyyy

Secondary Insurance* _______________________

Secondary Member ID #* _________________________

Secondary Group Number _____________________

Address *(If different from above)*

____

Street Address

____

Address Line 2 (PO Box, Apartment #, etc)

_______________________________________ _____________________________________

City *State*

____

ZIP Code

Secondary Insurance Phone # ________________________

On back of card

AUTHORIZATIONS

Release of Information*

☐ I authorize the release of any medical or other information (including psychiatric, HIV and drug and/or alcohol related) necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Person receiving services or authorized person's signature for release of information*

____ Date _____________________

Payment authorization*

☐ I authorize payment of medical benefits to the assigned physician or supplier for services provided at Child & Family Agency of Southeastern Connecticut, Inc.

Person receiving services or authorized person's signature for payment authorization*

____ Date _____________________