COASTAL HARBOR TREATMENT CENTER
SAVANNAH, GA

PATIENT NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____ / _____ / _____

PART A: INSURANCE COVERAGE ATTESTATION

I UNDERSTAND THAT FAILURE TO REPORT SECONDARY OR OTHER INSURANCE COVERAGE COULD RESULT IN A DENIAL OF PAYMENT BY THE PATIENT'S INSURANCE, AND THAT I COULD BE HELD FINANCIALLY RESPONSIBLE IF I WILLFULLY FAIL TO DISCLOSE THIS INFORMATION. _____ **(Initial)**

☐ I hereby attest that the above-named individual **IS NOT** covered under any insurance policy of which I am aware **other than that which is listed on the Patient Registration Form.**

☐ I hereby attest that the above-named individual **IS** covered under another insurance policy **other than that which is listed on the Patient Registration Form** and that information is listed below.

X _____	_____	X _____
Signature of Parent/Guardian	Signature of Co-Parent/Guardian	Date
_____	_____	_____
Signature of CHHS Witness	CHHS Staff Title	Date

PART B: COORDINATION OF BENEFITS

PLEASE COMPLETE EACH SECTION IN FULL. IF ANY INFORMATION IS UNKNOWN, PLEASE INDICATE SUCH.

Your policy contains a "coordination of benefits" provision that allows your insurance carrier to share responsibility in covering health care expenses with any other company covering you or your family for medical benefits. When health care expenses are shared between two or more companies, your financial responsibility may be reduced. If you have any questions regarding this form, please contact your insurance company by calling the number listed on the back of your card.

NATURAL FATHER

Name _____ DOB _____ SSN _____

Address/Phone _____

Employer _____ Occupation _____

Employer Address/Phone _____

Is the patient covered under his/her natural father's insurance/health plan? ☐NO ☐YES

If Yes: Health Plan Name _____ Policy # / Member ID _____

NATURAL MOTHER

Name _____ DOB _____ SSN _____

Address/Phone _____

Employer _____ Occupation _____

Employer Address/ Phone _____

Is the patient covered under his/her natural mother's insurance/health plan? ☐NO ☐YES

If Yes: Health Plan Name _____ Policy # / Member ID _____

STEPPARENT / OR OTHER GUARDIAN

Name _____ DOB _____ SSN _____

Address/Phone _____

Employer _____ Occupation _____

Employer Address/ Phone _____

Is the patient covered under his/her stepparent/other guardian's insurance/health plan? ☐NO ☐YES

If Yes: Health Plan Name _____ Policy # / Member ID _____

(PLEASE COMPLETE REVERSE)

PART C: ADDITIONAL INSURANCE COVERAGE

PLEASE COMPLETE EACH SECTION IN FULL. IF ANY INFORMATION IS UNKNOWN, PLEASE INDICATE SUCH.

Is the above-named individual covered by **MEDICAID?** ☐ NO ☐ YES

If Yes: Medicaid Number: _____ Effective Date: _____

Plan Type: _____ Member Number: _____

Is the above-named individual covered under **ANY OTHER HEALTH INSURANCE** in addition to the coverage listed above and on the Patient Registration Form? ☐ NO ☐ YES *If Yes, please complete the following section.*

Health Plan: _____ Telephone Number: _____

Name of Insured: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____

Address/Phone: _____

Employer: _____ Occupation: _____

Employer's Address/Phone: _____

Policy # / Member ID: _____ Group #: _____

Health Plan: _____ Telephone Number: _____

Name of Insured: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____

Address/Phone: _____

Employer: _____ Occupation: _____

Employer's Address/Phone: _____

Policy # / Member ID: _____ Group #: _____

I certify that the above information is true and correct. I authorize the administrator of the above named plan(s) to release information to my insurance carrier regarding health care benefits to which I may be entitled. I understand that the purpose of the release of information is to assure appropriate coordination of benefits of all plans. This authorization shall remain valid for the duration of the coverage of the plan for which a claim is submitted. I understand a photocopy of this authorization shall be valid as the original.

X _____ _____ X _____

Signature of Parent/Guardian | Signature of Co-Parent/Guardian | Date

_____ _____ _____

Signature of CHHS Witness | CHHS Staff Title | Date