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

COASTAL BEHAVIORAL HEALTH
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 and that information is listed below.

X _____ X _____

Signature of Patient/Guardian — Date

_____ _____

Signature of CHHS Witness — CHHS Staff Title

PART B: COORDINATION OF BENEFITS

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.

PATIENT

Name _____ DOB _____ SSN _____

Address/Phone _____

Employer _____ Occupation _____

Employer Address/Phone _____

Is the patient covered under his/her own insurance/health plan? ☐NO ☐YES

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

SPOUSE

Name _____ DOB _____ SSN _____

Address/Phone _____

Employer _____ Occupation _____

Employer Address/ Phone _____

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

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

PARENT/ LEGAL GUARDIAN

Name _____ DOB _____ SSN _____

Address/Phone _____

Employer _____ Occupation _____

Employer Address/ Phone _____

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

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

PART C: ADDITIONAL INSURANCE COVERAGE

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 by **MEDICARE?** ☐ NO ☐ YES

If Yes: Medicare Number: _____ Effective Date: _____

Plan Type: _____

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 Patient/Guardian Date

_____ _____

Signature of CHHS Witness CHHS Staff Title