



LARSEN BILLING SERVICE

Please send this form to your LBS account representative. To find your rep's e-mail or fax number please visit our web-site at www.larsenbilling.com

Client Registration Form (CRF)

Providers: Please send this form to your biller at the beginning of care with your client. This is step one in the billing process. In order to submit a test claim, please complete the Test Claim Superbill and send it to your assigned biller for processing.

Provider Name and Credentials: _____

Facility Name: _____ **or Business Name:** _____ (if applicable)

CLIENT INFORMATION *Please provide your e-mail address if you would like to receive a copy of your completed benefits.

Name (Last, First, MI) _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone(____) _____ Cell Phone(____) _____ Email _____

Marital Status: single married widowed separated divorced Birthdate _____ Age _____

Soc. Sec # _____ Due Date _____ LMP _____ First Pregnancy? Yes No

Planning home or birth center birth? Home Birth center (if applicable) _____

INSURANCE INFORMATION Insurance Only LBS Pay Plan Only BOTH Insurance and LBS Pay Plan

Primary Insurance _____ Plan Name _____ Effective _____

Insurance Address _____ City _____ State _____ Zip _____

Insurance Phone# (for providers) _____ Electronic Payor ID# (5 digits) _____

Subscriber's Name _____ Male Female Subscriber's Birthdate _____

Subscriber's SS# _____ ID# on Card _____ Group# _____

Subscriber's Employer: _____ Client's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance _____ Plan Name _____ Effective _____

Insurance Address _____ City _____ State _____ Zip _____

Insurance Phone# (for providers) _____ Electronic Payor ID# (5 digits) _____

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber's SS# _____ ID# on Card _____ Group# _____

Subscriber's Employer: _____ Client's Relationship to Subscriber: Self Spouse Child Other

Notes/instructions regarding this CRF: _____

I certify that the information on this form is correct to the best of my knowledge. I authorize Larsen Billing Service to verify my insurance benefits on my behalf for the fee of \$15, which I will pay one of two ways as indicated below. I hereby authorize my insurance company to make payment directly to my provider should claims be filed. I give authorization to my provider to release any information necessary to process my benefits or insurance claims. I understand the final outcome for my insurance benefits level and the processing of my claims is under the discretion of the insurance company. I will not hold Larsen Billing Service or my midwife responsible for the information reported on this verification or the manner in which my claims process.

Signature of Client: _____ **Date:** _____

Client Initials: _____ In some cases insurance claims may deny and require an appeal process. In this circumstance, I authorize Larsen Billing Service (LBS) to pursue appeals on my behalf. I understand this will be at the discretion of LBS and there is no additional charge for this service. I also understand that it may be necessary for LBS to contact me via e-mail or by telephone if appeals are pursued. (*Please provide your e-mail address in the top portion of this form.)

Please select one payment option below:

I will pay \$15.00 online through the LBS website at www.larsenbilling.com

I will pay \$15.00 to my provider/midwife