CHATT / CHAT Insurance Verification Form

Child Name_____

Parent/Family_____**Phone#**_____

Parent/Insured Address_____

City_____**State**_____ **Zip**_____

[ ] My child/family does not have private/employer-provided health insurance. Please bill the autism waiver program directly for therapy services rendered.

[ ] My child/family has private/employer provided health insurance, and I have provided the required information for billing it below. As required by the autism waiver program, please bill my private insurance first, before seeking reimbursement from the waiver.

Parent/responsible party signature_____**Date**_____

Insurance Payment Authorization/Signature on File Authorization

Primary Medical Insurance Company: _____
(Please include copy/copies of both sides of insurance card with this form, or scan/photo and email to cryan12@msn.com).

I hereby authorize you [insurance company(s)] to pay directly to the below named office benefits due to me out of indemnity under the terms of my policy issued by your company, or benefits due under the terms of any separate service and payment agreement negotiated between [insurance company(s)] and below named office(s).

Childhood Autism Treatment Team (CHATT) DBA Childhood Autism Therapies LLC
Director: Colleen Ryan, PhD. Business Manager: Mike Rubingh.
(1) N1563 County Rd H, Palmyra WI 53156. (2) 106 Main St. Palmyra WI 53156.
Phone: 262-370-7744, Billing Phone: 262-370-5527, Fax: 262-495-8689

I authorize the use of this form for any current and future medical insurance submissions, with payment made directly to the doctor/doctor's business. I authorize the use of this form for any release of information required by CHATT/CHAT. I permit a copy of this to be used in place of the original. Payment by insurer(s) of the amount billed by CHAT for therapy, in whole or part, shall be considered the same as if paid, by your company, directly to me (the insured). I submit the following info necessary for insurance billing.

Patient Name:	Patient DOB:
Insured Person Name:	Insured DOB (if different):
Insurance ID#:	Insurance Policy#:
Employer or School Name:	Insurance Group#:

1. I understand I am ultimately responsible for payment in full for services provided by the therapists of CHAT. I authorize CHAT to act as my agent in helping me obtain payment from my insurance carrier(s). Eventual reimbursement or coverage will be determined by your insurance carrier.
2. I understand that CHAT, as a typical provider may bill me for any co-pays and deductibles that are not paid by insurance or reimbursed by the state, unless expressly forbidden by the waiver program. If I decide voluntarily to end waiver eligibility, I will be responsible for any co-pays and deductibles not paid by insurance or the state that are due to CHAT for services provided. I will inform CHATT of any insurance changes or job changes that may affect my insurance coverage so the best response ensuring therapy continues can be made.

I agree to the above billing policies and authorization for billing

Patient _____ Date_____

Parent or responsible party_____
Relationship to patient_____