Midwife's Billing Service, Inc.

MW Code: BMA

58 Bullard Pasture Road, Wendell, MA 01379 • Tel: (978) 544-3551 • Fax: (978) 544-3560 • Email: MWBILLSERV@AOL.COM

New Client Registration Form

In order to avoid delays in payment please make sure all information is complete and correct.

Client Information

Client's Name: _____ Home Tel _____ Wk Tel _____ Cell _____ Email _____

Address: Street _____ City _____ State _____ Zip _____

Birth Date: _____ SS# _____ Marital Status _____ Student Status _____

LMP _____ First Consult Date _____ Due Date _____

❑ Midwife Services Only ❑ Facility Only ❑ Midwife & Facility ❑ Prevent. Care Only Planned Birth Site: ❑ Home ❑ Birth Center ❑ Hospital

Name of Referring Doctor (if applicable) _____ Referral on file yes or no

Name of Back Up Hospital or Planned Birthing Hospital (in the event of a transport) _____

In case of emergency please contact _____ Tel# _____

Policy Holders Information (if other than client)

Name: _____ Birth Date: _____ Relationship to Client: _____ SS#: _____

Address (if different than client): Street _____ City _____ State _____ Zip _____

Employment Status: ❑ Full ❑ Part Time Retired ❑ Active Duty ❑ N/A Tel# _____ Wk Tel# _____

Insurance Information

Name of Primary Insurance Company: _____

Address: Street _____ City _____ State _____ Zip _____

Telephone # _____ Is this a COBRA plan? _____

ID# _____ Group# _____ Plan Name _____

Name of Secondary Insurance Company (if applicable) _____

Address: Street _____ City _____ State _____ Zip _____

Telephone # _____ Is this a COBRA plan? _____

ID# _____ Group# _____ Plan Name _____

Additional Information

If you have made special arrangements with your insurance company such as receiving permission to see a provider who is normally not covered in your plan, or if you have received a prior authorization # or precertification # or if you have a contact person who we may call if necessary please let us know in the space below.

Midwife Use Only • Financial Details for Full Patient Accounting Only

❑ Estimated total amount out of pocket *This refers to clients deductible, co-insurance or co-pay* To be paid by _____

❑ Facility Fee Deposit To be paid by _____

❑ Maternity Care Deposit Total _____ To be paid no later than _____

❑ Other Arrangements *Please give specific details.*

Privacy & Assignment Statement: I authorize the release of any medical or other information necessary to process this claim within the guidelines set forth by HIPAA. I hereby authorize payment directly to the Midwife listed above. I understand that I am financially responsible for charges not covered, my deductible if not already met, and any co-payments or co-insurance. I have received and read my providers privacy policy and understand that my claims will be billed through Midwife's Billing Service, Inc.

X _____

Print Name Signature Date