



LARSEN BILLING SERVICE

Send form to LBS rep: Vanessa Romero
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Toll-free phone: (866) 476-0565

Client Registration Form (CRF)

Heaven Sent Birth Center

Margaret Scott, CPM

Provider's office must complete this box, unless a superbill will accompany this CRF when you submit to LBS:

For test claim, bill: Pregnancy confirmation visit (if before 20 weeks): straightforward detailed
Initial OB visit (for late transfers): straightforward detailed complex comprehensive

Date of service: _____ Comments: _____

CLIENT INFORMATION

Name (Last, First, MI) _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone(____) _____ Alternate 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 _____

INSURANCE INFORMATION

Primary 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

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 hereby authorize my insurance company to make payment directly to my provider. I also give authorization to my provider to release any information necessary to process my insurance claims.

Signature of Client: _____ Date: _____

I choose to hire Larsen Billing Service to verify my benefits, obtain authorizations as needed, and attempt in-network exceptions. I understand that my midwife will be billed \$15 for this service; I will pay my midwife for this fee (*please do not send checks directly to Larsen Billing Service*).

I choose to verify benefits myself. I understand that I must submit a completed Verification of Benefits form to my midwife as soon as possible in order for Larsen Billing Service to bill claims on my behalf. If I obtain incorrect benefits information, I will not hold Larsen Billing Service or my midwife responsible for the way in which my claims process. If I have trouble with the verification, authorization, or exception processes, I understand that I may choose to hire Larsen Billing Service at a later date for the fee of \$15.