

**Client Registration for Insurance Benefits**  
**Karin Hoskin, CPM**

Check here if you want LBS to verify your benefits (there will be a \$15 fee)

**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 \_\_\_\_\_  
Date of initial exam (not interview): \_\_\_\_\_ First pregnancy? Yes No

**INSURANCE INFORMATION**

**Primary Insurance** \_\_\_\_\_ Plan Name \_\_\_\_\_ Effective \_\_\_\_\_  
Ins. Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Ins. Phone \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_  
ID# on Card \_\_\_\_\_ Group # \_\_\_\_\_ Electronic payor ID# \_\_\_\_\_  
Client's relationship to Subscriber: Self Spouse Child Other

**Secondary Insurance** \_\_\_\_\_ Plan Name \_\_\_\_\_ Effective \_\_\_\_\_  
Ins. Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Ins. Phone \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_  
ID# on Card \_\_\_\_\_ Group # \_\_\_\_\_ Electronic payor ID# \_\_\_\_\_  
Client's relationship to Subscriber: Self Spouse Child Other

\*\*\*Verification of Benefits: Please call your insurance company and ask the following questions. -OR- Check the box at the top of this form to have Larsen Billing call and verify your benefits. There will be a \$15 fee for LBS to call.

Name of insurance rep spoken to \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
What is my eligibility date? \_\_\_\_\_ What is my out-of-network deductible? \_\_\_\_\_ How much of my deductible do I still need to meet? \_\_\_\_\_ Is this an HMO Plan? \_\_\_\_\_ Is a certified professional midwife covered by my plan? \_\_\_\_\_ Do I need a referral or authorization for maternity care or newborn care? \_\_\_\_\_ (Number to call if yes) \_\_\_\_\_ (call and get auth#) \_\_\_\_\_  
What percentage of the Usual and Customary will be paid for maternity care (CPT code 59400)? \_\_\_\_\_ (The remaining \_\_\_\_\_ % is my responsibility.) When does my baby need to be added to the plan? \_\_\_\_\_ Is baby's deductible included in mine? \_\_\_\_\_ If not, how much is baby's deductible? \_\_\_\_\_ Will insurance reimbursement be sent to the provider or to me? \_\_\_\_\_ Is pregnancy a pre-existing condition? \_\_\_\_\_  
If I want an in-network exception (because there are no contracted midwives in my area), what number do I call? \_\_\_\_\_  
Comments \_\_\_\_\_