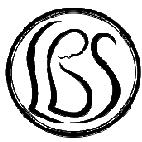 LARSEN BILLING SERVICE

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

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

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:______________________________

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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. I authorize Larsen Billing Service to verify my insurance benefits on my behalf for the fee of **$15**. I understand the final outcome for the processing of my claims is under the discretion of the insurance company and I will not hold Larsen Billing Service or my midwife responsible for the way in which my claims process.

Signature of Client:______________________________ **Date:** __________

Client--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.

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