



# Department of Public Health and Human Services

Business and Financial Services Division ♦ Reimbursement ♦ 525 East Mercury ♦ Butte MT 59701 ♦

Voice: 406-496-5407 ♦ Fax: 406-496-5431

**Steve Bullock, Governor**

**Richard H. Opper, Director**

Facility: Montana Chemical Dependency Center Date of this admission or renewal \_\_\_\_\_

## **AUTHORIZATION TO RELEASE HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES**

Client name \_\_\_\_\_ SS# \_\_\_\_\_ Client ID # \_\_\_\_\_

**Medicare** ID # \_\_\_\_\_ Part A date \_\_\_\_\_ Part B date \_\_\_\_\_ Part D Date \_\_\_\_\_

**First Insurance** \_\_\_\_\_ Insured's group # \_\_\_\_\_

Address \_\_\_\_\_ Certificate # \_\_\_\_\_

\_\_\_\_\_ Employer Group Name \_\_\_\_\_

Phone \_\_\_\_\_ Policyholder \_\_\_\_\_

Benefit types: \_\_\_\_\_ Address \_\_\_\_\_

MH Claims mailing address \_\_\_\_\_

Relationship to client \_\_\_\_\_ Rx Claims mailing address \_\_\_\_\_

Policyholder's ID # \_\_\_\_\_ Policyholders DOB \_\_\_\_\_

**Second Insurance** \_\_\_\_\_ Insured's group # \_\_\_\_\_

Address \_\_\_\_\_ Certificate # \_\_\_\_\_

\_\_\_\_\_ Employer Group Name \_\_\_\_\_

Phone \_\_\_\_\_ Policyholder \_\_\_\_\_

Benefit types: \_\_\_\_\_ Address \_\_\_\_\_

MH Claims mailing address \_\_\_\_\_

\_\_\_\_\_ Relationship to client \_\_\_\_\_

Rx Claims mailing address \_\_\_\_\_ Policyholder's ID # \_\_\_\_\_

\_\_\_\_\_ Policyholders DOB \_\_\_\_\_

**MEDICAID** ID # \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION AND DIRECT PAYMENT:** A bill/claim will be sent to an insurance company or to a government program to get paid. This bill has all the information about what services you had. We only share information about you that is needed by the payer to process the bill/claim.

I hereby authorize the provider noted above to release medical information necessary to process claims for payment of services, and authorize payment of benefits otherwise payable to me directly to the Department of Public Health & Human Services. This authorization is good for as long as you remain a client at this or another State facility.

**Signature:** \_\_\_\_\_

Date: \_\_\_\_\_