

Genetic Financial Assistance Application

Families requesting financial assistance for genetic laboratory testing must complete this application. If the applicant is covered by Healthy Montana Kids Plus (HMK+) or Medicaid please complete the front side of the form. If the applicant has health care coverage please complete both sides of the form. This information will be used to allow release of information to appropriate medical providers. It will be kept strictly confidential. Please provide all the requested information.

Patient's Name _____ Date of Birth _____
Social Security No. _____ Gender _____ Race _____
Home Phone _____ Message Phone _____
Mailing Address _____ County of Residence _____
City _____ State _____ Zip _____

Genetic Test Requested _____

Physician _____ Phone Number _____
Address _____
City _____ State _____ Zip _____

Medical Specialist _____ Phone Number _____
Address _____
City _____ State _____ Zip _____

Father _____
Address if different than above _____
City _____ State _____ Zip _____

Mother _____
Address if different than above _____
City _____ State _____ Zip _____

Legal Guardian if different than above _____ Phone Number _____
Address _____
City _____ State _____ Zip _____

If applicant is enrolled with Medicaid, please list card number here: _____

Release of Information:

I certify that the information I have given is true to the best of my knowledge. I give permission to the State of Montana to make any necessary contacts to check my statements. I agree to allow providers to release any medical, social and insurance information about my child to CSHS upon request in order to process the application for genetic financial assistance. Once information is provided to CSHS, I hold the provider harmless for subsequent disclosures of this information by CSHS. If I knowingly give false information, I understand that I must reimburse the State of Montana for any costs incurred, and any assistance from CSHS will terminate. This release is effective for 18 months from date signed.

Revocation Statement: I understand I have the right to revoke the above authorization for the release of information at any time by contacting CSHS in writing. CSHS, PO Box 202951, Helena MT 59620.

Signature (Parent or Legal Guardian)

Date



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HEALTH INSURANCE INFORMATION: Please attach a copy of your insurance card(s).

If the applicant has health care coverage please supply information below:

SUBSCRIBER – CARD HOLDER INFORMATION:

Subscriber (Name) _____ Subscriber (Date of Birth) _____

Subscriber (Social Security Number) _____

Subscriber (Employer) _____ City/State Employed In _____

INSURANCE COMPANY INFORMATION:

Insurance Company
(Name) _____

Address where claims are sent _____
City _____ State _____ Zip _____

Insurance Company (Phone Number) _____

Policy Number on Card _____ Eligibility Start Date _____

Group Number on Card _____ Eligibility End Date _____

The Department of Public Health and Human Services (DPHHS) does not discriminate on the basis of race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability, or national origin. If you believe you have been subjected to discrimination, contact the DPHHS Human Resources Division at 406.444.3136 or the Montana Human Rights Bureau at 800.542.0807, or Relay service at 711.

RETURN THIS APPLICATION TO:
CSHS, PO Box 202951, Helena MT 59620-2951
(406) 444-3622 (local) or (800) 762-9891 (in state)
Fax: (406) 444-2750



7/02/2013