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

Sheila Hogan, 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:_____________