INSURANCE INFORMATION

Patient Name:____Date of Birth_____________________
Address: ____
City, State, Zip:______________________________ Patient phone:______________________________
Email ____
Date of Last Menstrual Period:__________________ Estimated Date of Delivery______________________

Primary Insurance Holder's Name:_______________________________________ Gender_________
Address of Primary Subscriber (if different from above)____
____

Date of Birth of Primary Subscriber:__________________Relationship to Patient______________________

Name of Insurance Company____
Member ID number ____ Group number________________
Customer Service Phone Number:____
Payer ID or EDI number (usually a five digit number) ____

Do you have Out-of-network benefits? _____ Yes ____ No ___ I Don't Know
What is your out-of-network deductible? ____________ or ___ I Don't Know
Do You have Maternity benefits? ______ Yes ____ No ____ I Don't Know
Do you have any other insurance coverage? _____Yes ____ No

If you have additional insurance, please list the following:
Name of Second Insurance:____
Address:____
Phone number:____ Payor ID or EDI_____________

Subscriber's Full Name:____ Gender _______
Subscriber's Address:____
City, State, Zip:____
Relationship to Patient: ____

Member ID: ______________________________________ Group number:_____________________

Do you have Out-of-network benefits? _____ Yes ____ No _____I Don't Know
Do You have Maternity benefits? ______ Yes ____ No _____ I Don't Know
What is your out-of-network deductible? ________________ or _____ I Don't Know

Name of Midwife: and/or Birth Center: ____

Please fax completed forms to your midwife's account manager.
Benefits will be verified and the results will be given to your midwife.

Faith 888-329-2091

Congratulations on your pregnancy!

Midwives care about mothers, babies and families. They want birth to be good! They want families to be excited and supported; not scared and controlled. Midwives hate the process of fighting with insurance companies to get claims paid! Dealing with insurance is not a part-time job. Midwives want to be available to care for their clients' health needs; not on the phone for hours debating with insurance companies about payment. That is why your healthcare provider has contracted with National Birth Centers to file insurance claims. Things you need to know:

1. Letters or EOBs from your insurance will have our corporate address on it. Our corporate offices are in San Antonio TX. It does not mean you received care in Texas, it is the mailing address for your claims.
2. We employ over 120 midwives from Florida to Washington state. Some insurance companies have a midwife's name embedded in their computer for *any* claims that process under our corporate tax number. Please don't let this alarm you. We have tried to get this changed but the insurance company say if the actual rendering provider and the provider on the EOB or check are both affiliated with our corporation, it is not a problem.
3. Our corporate name is National Birth Centers, Inc. Checks are paid to the corporation and we pay your midwife. Occasionally there might be another name on the check. We have a few different contracts that apply to certain payers. If you are concerned, please email your midwife and she will forward to the corporate offices and someone will get back to you with an explanation.
4. Processing claims properly and paying staff to follow-up the insurance companies adds up; we don't charge upfront to process claims or check benefits; however, we charge 35% of the total paid on the claim to cover our investment of time and work.
5. Centers for Medicaid and Medicare in Washington DC define a birth center as a place that provides for labor, delivery and immediate postpartum as well as immediate newborn care. Birth Centers can be mobile and our contracts with payers acknowledges that. For the purpose of insurance claims, any place your midwife provides a setting for your delivery is considered a birth center.
6. Regardless of what an EOB might state, the financial agreement you have with your midwife stands. You are only responsible for your out-of-network deductible and co-pay . If you paid more than that combined amount, you will get a refund depending on how your claims pay!
7. The money you pay upfront is applied to the midwife's professional fees, if the amount you pay exceeds your out-of-network deductible and co-insurance, you will get a refund when your claims pay. If your deductible is very large, we can file and see what happens. Your original agreement still stands with your midwife and will will not owe more money, no matter what happens with your claims.
8. You can not profit from your insurance on your health care, if you receive a check from your insurance company, you agree to mail it to our corporate offices or give it to your midwife. You will be issued a refund if appropriate after the payment is processed.
9. If an EOB statement concerns you, please email your midwife with questions and she will forward to her claims manager. We are more than happy to answer your questions.
10. Thank you for the opportunity to work with you and your midwife in getting your claims paid!

☐ I want National Birth Centers to submit claims to my insurance for all billable services I receive.

☐ I want to pay cash for the midwife's professional services. I will handle my own claim for professional services. I understand the midwife will submit a facility claim.

Signature of Insured Date

ASSIGNMENT OF BENEFITS ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested and/or received professional healthcare services from a healthcare provider associated with National Birth Centers Inc. on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for charges incurred during the course of said services. I understand that fees for services rendered are due and payable on the date of service and agree to pay such charges according to the arrangements have been made.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to National Birth Centers, Inc. I certify that the health insurance information that I have provided to my provider is accurate as of the date set forth below and that I am responsible for keeping all health insurance information updated.

I hereby authorize National Birth Centers, Inc. and any affiliates on behalf of me and my healthcare provider to submit claims, on my, and/or my dependent's behalf, to the benefit plan (or administrator) listed on the current insurance card I provide in good faith. I also hereby instruct my benefit plan (or its administrator) to pay directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to National Birth Centers I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and my provider upon request. Upon proof of such non assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to my healthcare provider.

I am aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services are paid in full. I understand that I am responsible to pay my deductible and coinsurance.

Authorization to Release Information

I hereby authorize my health care provider to: (1) release any information necessary to my health plan (or its administrator) regarding my treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize and convey to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit pan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from [Name of Provider] and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

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Insurance Company　　　　　　　　　　　　　　　　　　　　Phone number

____

Insurance Address　　　　　　　　　City　　　　　State　　　　　Zip

____

Member ID:　　　　　　　　　　　　　　　　Group No

____

Printed Name of Patient　　　　　　　　　　　　DOB

____

Patient Signature　　　　　　　　　　　　　　　Date

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