Expert Mental Health Care Across the Life Span

7617 Mineral Point Road | High Point Plaza, Suite 300, Madison, WI 53717-1623 | (608) 833-9290 | Fax (608) 833-9691 |

HEALTH INSURANCE CLAIM AUTHORIZATION

Name: ________________________________ **DOB:** ________________

Client's or Authorized person's signature.
I authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits to myself or to the party who accepts the assignment.

Insured's or Authorized person's signature.
I authorize payment of medical benefits to the undersigned physician or supplier for services described.

You must notify TPC at the time of *ANY CHANGE* in your insurance status, including *but not limited* to a change in your insurance provider, loss of insurance coverage, or Medicare or Medicaid eligibility.

If you fail to notify TPC timely of such a change and TPC is unable to bill for or collect fees from an insurer (including Medicaid or Medicare) due to your lack of notice, then *TPC may require you to pay for all unbilled or uncollected fees* to the extent allowed by law.

Signed____________________________________

Date___________________