LIFE PATTERNS INC.

Insurance Verification Form

Individual Receiving Services: _____

Is this individual covered under any insurance company *other than* Medicaid/KanCare?

YES _____ **NO _____**

If **YES**, please complete the following information:

Insurance Company Information

Name of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Name of Policy Holder: _____ Date of Birth: _____

Policy Holder's Employer: _____

Relationship to Individual Receiving Services: _____

Policy Number: _____ Group Number: _____

******PLEASE ATTACH A COPY OF YOUR INSURANCE CARD(S), BOTH FRONT AND BACK SIDES******

Authorization for Release of Information and Assignment of Insurance Benefits

I hereby authorize Life Patterns, Inc. to release information from my personal health records necessary for purposes of processing and payment of claims, coordination of benefits, and other functions that Life Patterns, Inc. is required by my health plan or other third-party payers to perform. I authorize Life Patterns, Inc. to bill my health plan and other third-party payers, directly on my behalf, and to receive direct payment of authorized benefits. I understand that I have a right to revoke this authorization at any time by providing written notice to Life Patterns, Inc., but the revocation does not apply to information that has already been disclosed prior to the revocation.

_____ _____

Signature of Individual Receiving Services or Legal Representative Date