



# LARSEN BILLING SERVICE

Please send this form to your LBS account representative. To find your rep's e-mail or fax number please visit our web-site at [www.larsenbilling.com](http://www.larsenbilling.com)

## Client Registration Form (CRF)

Providers: please send this form to your biller at the very start of care with your client. This is step one in the billing process.

**Transitions Midwifery Services, LLC**  
**Brandy Brandfass, RN, LM, CPM**

**Provider's office must complete this box, unless a superbill will accompany this CRF when you submit to LBS:**

For test claim, bill Initial OB exam (check ONE box):

Providers: in the event an initial exam has not been completed when first sending this CRF, please e-mail this info to your biller once the care occurs.

99205 (60 min-10 body systems-complete medical history-high decision making)

99204 (45 min-10 body systems-complete medical history-moderate decision making)

99203 (30 min-6 body systems-pertinent medical history-low decision making)

This is a returning established patient that I have provided care for in the past 3 yrs. Details regarding visit: \_\_\_\_\_

**Date of service:** \_\_\_\_\_ **Comments:** \_\_\_\_\_

### CLIENT INFORMATION

Name (Last, First, MI) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Alternate Phone(\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Marital Status: single married widowed separated divorced Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Soc. Sec # \_\_\_\_\_ Due Date \_\_\_\_\_ LMP \_\_\_\_\_ First Pregnancy? Yes No

Planning home or birth center birth? Home Birth center (if applicable) \_\_\_\_\_

### INSURANCE INFORMATION

**Primary Insurance** \_\_\_\_\_ Plan Name \_\_\_\_\_ Effective \_\_\_\_\_

Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone# (for providers) \_\_\_\_\_ Electronic Payor ID# (5 digits) \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Male Female Subscriber's Birthdate \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ ID# on Card \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Client's Relationship to Subscriber: Self Spouse Child Other

**Secondary Insurance** \_\_\_\_\_ Plan Name \_\_\_\_\_ Effective \_\_\_\_\_

Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone# (for providers) \_\_\_\_\_ Electronic Payor ID# (5 digits) \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Birthdate \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ ID# on Card \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Client's Relationship to Subscriber: Self Spouse Child Other

Notes/instructions regarding this CRF: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that the information on this form is correct to the best of my knowledge. I hereby authorize my insurance company to make payment directly to my provider. I also give authorization to my provider to release any information necessary to process my insurance claims. I authorize Larsen Billing Service to verify my insurance benefits on my behalf for the fee of \$15. I understand the final outcome for the processing of my claims is under the discretion of the insurance company and I will not hold Larsen Billing Service or my midwife responsible for the way in which my claims process.

**Signature of Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_