



NEVADA YOUTH EMPOWERMENT PROJECT



INSURANCE RESOURCES/ CONSENT TO BILL

Intake (initial completion) Date _____
 Update _____ Date _____

1. Client's Name _____ Date of Birth _____

2. MEDICAID FFS (required)

Currently Enrolled Medicaid # _____
 Application Pending Date Submitted _____
 Date of Application Date Due: _____ Date Submitted: _____

3. PRIVATE INSURANCE RESOURCES

Policy Holder Information:

Name _____ Insured's Relationship to Policy Holder _____
Street _____ Telephone _____
City, State, Zip _____

Insurance Company Policy Holder Information:

Name _____ Policy # _____
Street _____ Member/ID# _____
City, State, Zip _____ Group/Acct# _____
Telephone _____ Effective Date _____ Termination Date _____

Plan (check all that apply) Employer Self Purchase HMO PPO Nevada Youth Empowerment Project



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4. CONSENT TO BILL MEDICAID FOR NYEP SYSTEM SERVICE

NYEP requests individuals served by NYEP to support the system providers to bill Medicaid and/or private Insurance companies for covered services. This request is made in order to be sure that NYEP funds can serve the largest number of persons possible. The consent is mandatory for residents.

Please check each box that applies, and sign to give permission to bill Medicaid and/or your insurance. Your signature indicates that you agree to the terms of this consent and allow NYEP providers to bill and accept payments from you or your child's health insurance plan(s).

I have been provided access to a list of providers for behavioral treatment and chose NYEP as my provider.

My signature below indicates this.

Consent to bill Medicaid. My signature below indicates that:

I give permission for providers of NYEP system services to bill Medicaid for covered services; and exchange of information necessary to secure payment for these services. (Such necessary information may include my diagnosis, service dates, types of services, and other information related to NYEP service systems necessary to process claims.)

I will notify my NYEP Case Manager of any changes in my Medicaid enrollment status.

Signature: _____

Date: _____

5.

Consent to bill insurance plan(s). My signature below indicates that:

I give permission for providers of NYEP system service to bill the insurance company (ies) listed above for covered services; and to exchange of information necessary to secure payment for these services. (Such necessary information may include my diagnosis, service dates, types of services, and other information related to NYEP system services necessary to process claims.)

I understand that if a payment is made directly to me for NYEP services, I am responsible for immediately sending such payments to the NYEP provider who delivered the service.

I will notify my NYEP Case Manager of any changes to my health insurance coverage, as well as any denial information.

Signature(s) of individual(s) holding _____

Date: _____

Authority to authorize insurance payment _____

Date: _____

Case Manager _____

Date: _____