



Department of Public Health and Human Services

Business and Financial Services Division ♦ Reimbursement ♦ 525 East Mercury ♦ Butte MT 59701♦

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Greg Gianforte, Governor

Charlie Brereton, Director

Facility: Montana Chemical Dependency Center Date of this admission or renewal _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES

Client name _____ SS# _____ Client ID # _____

Medicare ID # _____ Part A date _____ Part B date _____ Part D Date _____

First Insurance _____ Insured's group # _____

Address _____ Certificate # _____

_____ Employer Group Name _____

Phone _____ Policyholder _____

Benefit types: _____ Address _____

MH Claims mailing address _____

Relationship to client _____ Rx Claims mailing address _____

Policyholder's ID # _____ Policyholders DOB _____

Second Insurance _____ Insured's group # _____

Address _____ Certificate # _____

_____ Employer Group Name _____

Phone _____ Policyholder _____

Benefit types: _____ Address _____

MH Claims mailing address _____

_____ Relationship to client _____

Rx Claims mailing address _____ Policyholder's ID # _____

_____ Policyholders DOB _____

MEDICAID ID # _____

AUTHORIZATION TO RELEASE INFORMATION AND DIRECT PAYMENT: A bill/claim will be sent to an insurance company or to a government program to get paid. This bill has all the information about what services you had. We only share information about you that is needed by the payer to process the bill/claim.

I hereby authorize the provider noted above to release medical information necessary to process claims for payment of services, and authorize payment of benefits otherwise payable to me directly to the Department of Public Health & Human Services. This authorization is good for as long as you remain a client at this or another State facility.

Signature: _____

Date: _____