NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Location: SNAMHS ☐ NNAMHS ☐ RCHS BH ☐ RCHS CH ☐

Date:

INSURANCE ELIGIBILITY AND FINANCIAL INFORMATION FORM

AVATAR ID #:
(FOR STAFF USE ONLY)

SECTION 1 CLIENT INFORMATION

Name:	Social Security Number: __ __ __-__ __-__ __ __ __ Date of Birth: ___ / ___ / ___
Physical Address:	Gender: (Please check one) [ ]Male [ ]Female [ ] Transgender If Transgender, please indicate how you are identified in the Medicaid/Medicare system [ ]Male [ ]Female Thank you!
Mailing Address: Email: _____	Marital Status: (Please check one) [ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Separated
Other Contact Info: Home Number: (_____)_____-_____ Work Number: (_____)_____-_____ Cell Number: (_____)_____-_____	Are you employed? (Please check one) [ ]Yes [ ]No If yes, name and address of employer: _____ _____
(IF MARRIED): Spouse Name: Spouse Date of Birth: Spouse SS#:	Is spouse employed? (Please check one) [ ]Yes [ ]No If yes, name and address of employer:
Are you (or your spouse) a Veteran? [ ]Yes [ ]No If yes, Branch of Service: _____	

SECTION 2 FINANCIAL INFORMATION

FINANCIALLY RESPONSIBLE PARTY: **Check here if same as above:** ☐ Then go to # of Dependents & Income questions

Name: RELATIONSHIP TO THE CLIENT: _____	Social Security Number: __ __ __-__ __-__ __ __ __ Date of Birth: ___ / ___ / ___
Physical Address:	Other Contact Info: Home Number: (_____)_____-_____ Work Number: (_____)_____-_____ Cell Number: (_____)_____-_____
Mailing Address:	
Are you (or your spouse) a Veteran? [ ]Yes [ ]No If yes, Branch of Service: _____	Are you employed? (Please check one) [ ]Yes [ ]No If yes, name and address of employer:
Number of Dependents: _____ (Only dependents under age 18, full-time student living at home and claimed on parent's tax return, or other disabled dependent that qualifies for inclusion on tax return can be considered for establishing sliding scale-fee)	Gross Monthly Income: _____ Spouse Gross Monthly Income: _____ *(Income before deductions)

Other Income (please check all applicable sources):

[ ]SSI $_____ (PER MONTH) [ ]SSDI $_____ (PER MONTH) [ ]VA BENEFITS $_____ (PER MONTH)

[ ]MILITARY BENEFITS $_____ (PER MONTH) [ ]ALIMONY $_____ (PER MONTH)

[ ]CHILD SUPPORT $_____ (PER MONTH) [ ]UNEMPLOYMENT $_____ (PER MONTH)

[ ]TRUST ACCOUNT $_____ (PER MONTH) [ ]PENSIONS $_____ (PER MONTH)

[ ]SNAPS BENEFITS $_____ (PER MONTH) OTHER: $_____(PER MONTH) SOURCE: _____)

SECTION 3 INSURANCE INFORMATION

Please check ANY insurance benefits you receive currently: [ ]MEDICARE [ ]MEDICAID [ ]PRIVATE INSURANCE [ ]VA BENEFITS [ ] Vocational Rehabilitation [ ]IHS (Indian Health Services) [ ]VICTIMS OF CRIME **NOTE: You must present your insurance ID card in order to verify your benefits**.	**If you are new to Nevada and had Medicaid/Affordable Care Act (ACA) coverage in another State within the last 30 days, please indicate:** **State of Previous Residence: _____** **Date and Year of last month you were eligible for Medicaid/ACA benefits: _____**
Primary Insurance Coverage:	**Secondary Insurance Coverage:**
Insurance:	Insurance:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder:	Policy Holder:
Policy Holder's SS#:	Policy Holder's SS#:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Relationship to Insured:	Relationship to Insured:
Pharmacy:	Pharmacy Phone #:
Pharmacy Address/Location:	Coverage (Co-Pay):

SECTION 4 Consent, Self Attestation and Authorization

I attest through signature that the information provided herein is correct and complete to the best of my knowledge. I request my charges be based on the sliding fee scale in effect at the time services are received (*based on my gross annual income and number of dependents*). I understand that if I fail to provide written verification of income AND apply for Medicaid/ACA benefits, if requested, that I may be charged full cost for services received, based on current agency fee schedules in effect at the time services are received.

I authorize Nevada Division of Public and Behavioral Health (DPBH) to disclose Psychiatric/Drug/ETOH/HIV/general medical information, verbal disclosure and/or a copy of my protected health information as requested by company/agency indicated for the purpose of payment of claims.

I authorize DPBH to bill my insurance company for services provided. I further authorize my insurance company to pay claims directly to DPBH. I understand that I am responsible for payment of the full cost of services (or sliding scale-fee cost if applicable) regardless of how much insurance pays on my claims.

I agree to make reasonable efforts to resolve any payment problems with the DPBH Business Office and understand that, if an unpaid balance remains, my account may be referred for collections. I further agree to notify the Division of any changes in my income, insurance coverage, number of dependents, or any other information contained herein within 10 days of such changes.

_____

Signature of Patient Date

or

_____

Signature of Parent or Legal Guardian Date

TO BE COMPLETED BY STAFF:

Medicare: [ ] Yes [ ] No *If yes, proof of income is required.

Sliding Fee Scale at _____% Total Annual Income $ _____

Self-Attestation Approved: [ ]Yes [ ]No

Staff/Witness Signature: _____ Date: _____