Attn: **Insurance Billing**

1. Please have patient read and sign **Authorization for Release of Information/Assignment of Benefits**.
2. The Recommendation of Authorization must be attached to your returned billing.
3. **Complete** Sections 1, 2 and 3.
4. Dates of service and number of sessions must correspond to the Recommendation of Authorization. Any dates of service not authorized cannot be billed. Please submit a Request for Treatment Authorization (Renewal) form Attn: Utilization Review to request authorization.
5. For Late Cancellations and No-Show policy. Refer to your provider manual or contact Provider Relations.
6. Mail with **Attn: Claims Department** printed on envelope.
7. Timely billing for insurance patients is 90 calendar days from the Date of Service.

Section 1 – Member Section

Patient: ______________________________

Address: ______________________________

Social Security #: ____________________ Date of Birth: ____________________

Employee: ____________________ Insured I.D. #: ____________________

Employer: ____________________ Deductible: __________

Assignment of Benefits: ______________________________

Insured or authorized person's signature

Section 2 – Provider Section

Provider: ____________________ Authorization Code: ____________________

Signature: ____________________ ICD10: ____________________

Billing Address: ______________________________

Tax ID or Social Security #: ______________________________

Section 3

Dates of Service Covered by Insurance

Dates of Service	CPT Code	Explanation of Services	Billed Amount	Copayment Collected	Deductible Collected

The Holman Group
Managed Behavioral Health Care Services

Request & Authorization for the Release of Information

Assignment of Benefits Authorization

I understand that in order to assure the quality of services provided to me under the EAP/MAP/HMO, information regarding my medical records, my personal history (and/or family's), reports of psychological tests (which may have been administered), and diagnosis and plan or treatment reports, may be **confidentially reviewed** by a committee of professionals known as the Utilization Management Committee (UMC) and/or professional representatives of The Holman Group Quality Management (QM) staff.

I have discussed these procedures with ____________________________ who is authorized to provide relevant information to the Utilization Management Committee follow-up counselor. This confidential information will be used to assure quality of service you receive, ensure payment for authorized services is properly processed and to ensure the proper delivery of health care services. This information will not be used for any other purposes.

I understand that this will be for the purpose of planning and evaluating the services being made available to me and this information shall not be released to any other person, organization or company.

I understand that during and after my counseling, I will be receiving a follow-up call and/or questionnaire from the Holman Group. The purpose of this follow-up call will be to further assure that I received the assistance that I wanted.

I understand that this release of confidential medical information shall be valid for the period of my coverage under this group plan and that information obtained under this release will be used only for the furtherance of my treatment and in determining my benefits. The Holman Group will maintain the information provided for a period of seven years for adults and ten years for minors. After the expiration of this time, the information provided will be destroyed in a confidential manner.

I understand that if I reveal information concerning child abuse, intent to harm myself or others, or abuse to the elderly, the therapist/counselor is mandated by law to report it. All other matters will remain strictly confidential and privileged, except for purposes of professional review and follow-up.

I, the undersigned person, assume full personal financial responsibility for any psychological and counseling services rendered, other than the sessions which are contractually provided by the Holman Group.

I hereby authorize the payment of medical benefits directly to the provider, named above, by the Holman Group for services rendered to me.

I have received a copy of this Request and Authorization for Release of Information and hereby waive any additional reporting requirements governing notification during the process of exchanging information between the Holman Group and my provider during the course of treatment.

I understand that a photocopy/facsimile of this Request and Authorization shall be as valid as the original.

This Authorization authorizes the release of Protected Health Information pursuant to HIPAA regulations contained in 45 CFR Parts 160 and 164. This Authorization also authorizes the release of information under the California Confidentiality of Medical Information Act of 1980, Section 56 et. seq. of the California Code.

Requested By: Elliott Grumer, M.D. ____________________________
Dr. Elliott Grumer, M.D., Medical Director, The Holman Group Representative

Enrollee Signature: ____________________________ Date: ______________

Print Enrollee Name: ____________________________

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al núlmero de teléfono de su plan de salud al 1-800-321-2843. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1-888-466-2219.