Rock Cairn Counseling & Consulting, LLC

Personalized Direction for your Path

Authorization to bill Medical Mutual Insurance

By signing below, I request that payment be made and authorize the release of any information necessary to process the claim. I certify that information listed below is true, accurate and complete. The patient or authorized representative's signature authorizes any entity to release to Medical Mutual medical and non-medical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medical Mutual claim is made. See 42 CFR 411.24. If there is insurance in addition to Medical Mutual, the patient or authorized representative's signature authorizes release of information to the health plan or agency indicated.

Insured's Name:

Insured's ID Number:

Insured's Address:

Insured's Phone:

Insured's Date of Birth:

Patient's Name:

Patient's ID Number:

Patient's Address:

Patient's Phone:

Patient's Date of Birth:

Patient's Sex:

Patient's Relationship to Insured:

Does the patient have any additional insurance: Yes or No If yes, please list Any Additional Insurances & their information Below:

Client/Guardian/POA Printed Name Signature Date

Witness Printed Name Signature Date

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