Compassion Care In-Home Health

Consent to Bill Medicaid Form

Is this form a replacement for a previously submitted form? ☐ Yes ☐ No

Recertified Month: (Leave blank if not sure)

Release of Information & Consent to Bill Medicaid

Client First and Last Name:

Gender: ☐ Male ☐ Female ☐ Other

Date of Birth:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Social Security #:

Complete Address with City, Zip:

Home Phone Number:

Cell Phone Number:

Caregiver Cell Phone Number:

Email Address: (You will be emailed a copy of this form with the email provided here)

Medicaid Insurance Information

(If possible, please upload a copy of the Medicaid Card)

MEDICAID ID#:

The above information is accurate to the best of my knowledge. Any changes to the above information will be communicated with this office immediately. I, hereby authorize release of medical information that is necessary for my care / paid caregiver. I consent to release my information and I consent Compassion Care In Home Health LLC. to bill Medicaid.

Client Signature:

Caregiver's Printed Name:

Caregiver's Signature: