Mark A. Hackel
County Executive

Macomb County Community Mental Health

FOCUS

Client Insurance Authorization

IDENTIFYING INFORMATION			
NAME	CASE #	DOB	GENDER

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME

CONTRACT ID (ALL INSURANCE)

INSURANCE GROUP # (COMMERCIAL, BLUE CROSS) INSURANCE PHONE # (COMMERCIAL, BLUE CROSS)

SUBSCRIBER'S NAME

SUBSCRIBER'S DATE OF BIRTH RELATIONSHIP TO CONSUMER

SUBSCRIBER'S ADDRESS

CITY STATE ZIP

Consumer Insurance Authorization

I authorize Macomb County Community Mental Health (MCCMH) to release to the above Health Insurance Company(s) or its intermediaries or carriers, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance either to myself or to MCCMH.

My signature documents that the INSURANCE AUTHORIZATION has been explained to me, and that I agree with the above statements and information. My signature also documents that the fees to be charged for services and the process for communication with my health insurer(s) have been explained to my satisfaction.

RESPONSIBLE PARTY'S SIGNATURES

CONSUMER SIGNATURE (if applicable) DATE WITNESS SIGNATURE (if applicable) DATE

GUARDIAN'S SIGNATURE (if applicable) DATE WITNESS SIGNATURE (if applicable) DATE

PARENT'S SIGNATURE (if applicable) DATE

SIGNATURE OF PREPARER DATE ACCOUNT CLERK'S SIGNATURE DATE