Sieda BEHAVIORAL HEALTH AND TREATMENT SERVICES
HEATLH INSURANCE / T19 INFORMATION SHEET

INSURANCE / T19 INFORMATION:

Name of Insurance Carrier: _____

Phone Number: _____

Claims Mailing Address: _____

_____

POLICY HOLDER INFORMATION:

Name of Policy Holder: _____

Home Phone: _____

Address: _____

_____

Policy #: _____ DOB: _____

Employer Name: _____

Relationship to person served: _____

ASSIGNMENT OF BENEFITS:

I _____, hereby authorize Sieda Behavioral Health and Treatment Services to receive any insurance payments from the insurance company listed above, in compensation for services as itemized.

CONSENT TO RELEASE:

I authorize Sieda Behavioral Health and Treatment Services to release the following information to the agency specified above:

Duration of involvement with program and attendance
Summary of treatment participation
Legal, social and medical history
(Including all substance use disorder information)
Evaluation and recommendations
Alcohol and other drug history
Billing information

The purpose of the disclosure authorized in this consent is to:
Provide information necessary to submit for insurance payments and to assist in the collection of treatment fees.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires when final payment decision has been made by the insurance company and payment is received by SIEDA.

I understand that generally Sieda Behavioral Health and Treatment Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____

(Person Served Signature and Date) (Witness Signature and Date)