Welcome to Children Making Strides

Phone:508-563-5767 • Fax: 508-563-5774 • www.childrenmakingstrides.com • info@childrenmakingstrides.com

Insurance Application

Patient Information:

Child's Name:_____Nickname:_____
Address:_____City:_____State:___Zip:_____
Phone: (____)_____Parent's Cell: (____)_____
Patient DOB:____/____/_____ Patient SSN#:_____/_____/_____
Name of School Child Attends:_____

Parent / Guardian Info:

Mother's Name:_____
Mother's Phone:_____Best time to reach:_____
Mother's e-mail:_____

Father's Name:_____
Fathers's Phone:_____Best time to reach:_____
Father's e-mail:_____

Address (if different than above):_____
City:_____State:_____Zip:_____
How did you find out about us:_____

Insured Parent Information:

(Please attach copy of front and back of Insurance Card.)

Name of Insured:_____Insured DOB:_____
Relationship to patient:_____Insured SSN#:_____
Name of employer:_____Work Phone:_____
Address of employer:_____
City:_____State:_____Zip:_____
Name of Insurance Co:_____
Group #_____ID#_____
Member Service Phone # (_____)_____*(located on back of insurance card)*
Provider Service Phone (_____)_____*(located on back of insurance card)*

Do you have additional Insurance? If yes, complete the following:

Name of Insured:_____Insured DOB:_____
Relationship to patient:_____Insured SSN#:_____
Name of employer:_____Work Phone:_____
Address of employer:_____
City:_____State:_____Zip:_____
Name of Insurance Co:_____
Group#_____ID#_____
Member Service Phone #_____Provider Service Phone _____

Welcome to Children Making Strides

Phone:508-563-5767 • Fax: 508-563-5774 • www.childrenmakingstrides.com • info@childrenmakingstrides.com

To begin processing your child's application for either home base or center based services you need to complete the following checklist and return the completed forms to CMS. You can fax them to 508-563-5774 or email them to Danielle@childrenmakingstrides.com. If anything is missing our office will contact you.

- ☐ **Front and back of all applicable insurance cards.**
- ☐ **Copy of the original diagnostic report**
- ☐ **Letter from PCP or pediatrician stating that your child has the diagnosis of Autism Spectrum Disorder (F84.0) and that ABA is medically necessary for treatment**
- ☐ **Session Registration Form**
- ☐ **Copy of most recent physical**
- ☐ **Completed insurance application**
- ☐ **Completed information release (see below)**

Upon receipt of all the completed documents listed above, CMS will contact your insurance company to get authorization for an assessment and treatment plan. Depending upon the insurance company, this can take 2-3 weeks. As soon as we receive this authorization, we will contact you to set up and appointment for your child.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I hereby accept responsibility for any services provided to me that are not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance. If the practice does not participate with my insurance I agree to pay all copayments, coinsurance, and deductibles at the time service is rendered. I also authorize Children Making Strides, or insurance company to release any information required to process my claims. This also serves a records release authorization. I authorize CMS to speak to my insurance company, PCP, and all related parties and to disclose necessary information that will enable my child to receive services.

Parent/Guardian E-Sign:_____Date:_____

This signed authorization must be returned with the other forms listed above for us to process your child's application for services

If you have any questions or need additional information contact CMS at 508-563-5767