CHILDREN'S
Rehabilitation Service
Creating Partnerships ~ Building Futures

CHILDREN'S REHABILITATION SERVICE
BILLING INFORMATION FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

CLIENT INFORMATION

SSN: ____-____-____

Last name: _____ First: _____ Middle: _____ Suffix: _____

HEALTH INSURANCE INFORMATION

Change in health insurance within the last 12 months: ☐ Yes ☐ No If yes, please complete the following:

Insurance company name: _____ Code: _____

Policy contract number: _____ Policy group number: _____

Effective date: From: _____ To: _____

Pharmacy benefits? ☐ Yes ☐ No Check if: ☐ Point of sale or ☐ Drug co-pay Dental coverage? ☐ Yes ☐ No

Policy holder:

SSN: _____-_____-_____ Insured's relationship to client: _____

Last name: _____ First: _____ MI: ____ Suffix: _____

Birthdate: _____/_____/_____

Policy holder's employer: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Phone: (_____) _____-_____

Check if client has a second insurance policy: ☐ Please provide information on that policy on the back of this form. ⟶

Medicaid number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

EPSDT provider: _____

Name as it appears on the Medicaid card: _____

FAMILY FINANCIAL PARTICIPATION INFORMATION

Number of persons living in household: _____

Taxable annual household income as reported on last tax return(s): _____

NOTE: Taxable annual household income should include wages of all persons in the home who support the child. Retirement, survivor and disability benefits may be reported in lieu of wages.

The above information is true to the best of my knowledge. I understand that I will be required to complete this form each year that my child receives treatment through Children's Rehabilitation Service.

Date: _____ Signature: _____

For office use only

All-Kids: ☐ Yes ☐ No Opening diagnostic code(s): _____ Type of care coordination: _____

Family size: _____ Taxable annual household income: _____ CRS annual co-pay: _____

Financial plan: _____ Worker code: _____

Insurance company name: _____ Code: _____

Policy contract number: _____ Policy group number: _____

Effective date: From: _____ To: _____

Pharmacy benefits? ☐ Yes ☐ No Check if: ☐ Point of sale or ☐ Drug co-pay Dental coverage? ☐ Yes ☐ No

Policy holder:

SSN: _____-_____-_____ Insured's relationship to client: _____

Last name: _____ First: _____ MI: ___ Suffix: _____

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