Platte County Health Department

Today's Date ______________________

Legal Name:

First______________________M.I.______Last___________________________

Date of Birth_____________________ Age________ Sex ____________

Address______________________________City______________State______Zip____

Phone Number (816)___________________________________

Parent/Guardian Name____

Parent/Guardian Date of Birth_______________________________

Medicaid Insurance Plan Name: (Please Circle)

Blue Advantage - Family Health Partners - First Guard - Molina - MoCare

Health Care USA

Medicaid Number___________________________________

<u>Assignment on Insurance Benefits/Release of Medical Information:</u>
I hereby authorize treatment deemed necessary by the Platte County Health Department Provider. I also authorize the release of my medical records to any company to which I have applied for coverage. I request payment of medical insurance benefits to include major medical to be made directly to Platte County Health Department on any unpaid bills for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance if applicable.

Signature____

Date______________________________

<u>WIC STAFF ONLY:</u>

Office Visit _____ 99211	Pregnant Woman _____
Hemoglobin Check _____ 85018	Post Partum _____
___ V703	Breastfeeding _____
	Child Age _____
Parkville _____	**Platte City _____**