Community MENTAL HEALTH CLINTON • EATON • INGHAM
Together we can.

REGISTRATION INFORMATION

Today's Date:	*If you wish to have your health insurance billed, all Insurance information is required. *The Sliding Fee Discount is only based on family size and income.	☐ Initial ☐ Updated	Client SC#
Client Last Name:	Client First Name:		Middle Initial:
Client Date of Birth:	Client SSN *(optional)*:	Client Email:	
Address:	City:	State:	Zip Code:
County:	Mobile Phone:	Other Phone:	

GUARANTOR INFORMATION

Guarantor Name:	Guarantor Relationship:		
Address:	City:	State:	Zip Code:

HEALTH INSURANCE INFORMATION

Primary Insurance:	Contract #:	Subscriber Name:	Subscriber DOB:
Secondary Insurance:	Contract #:	Subscriber Name:	Subscriber DOB:
Tertiary Insurance:	Contract #:	Subscriber Name:	Subscriber DOB:
Current Primary Care Physician or Clinic:			

INCOME INFORMATION

☐ Employment ☐ No Income ☐ SSI/SSD/SS ☐ Worker Comp. ☐ Pension ☐ Other

HOUSEHOLD INCOME

Annual Gross Family Income	$
Other Household Income	$
SSI,SSD, SS Other Benefits	$
Total Annual Income	$

DEPENDENTS

Number of Household Dependents:	

Notes:

I certify that the above inforamtion is correct and I agree to notify CMH-CEI within two weeks of any change to this information, including name, living arrangement, income and insurance.

Further, I authorize payment directly to CMH-CEI for any third party benefits to which I am entitled, and authorize release of information needed to process third party claims.

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY/AUTHORIZATION TO RELEASE INFORMATION: I hereby, authorize payment directly to the provider for any third party benefits to which I am entitled. I hereby authorize release of information between the provider and benefit payers, including, as applicable deficiency syndrome (AIDS) or AIDS-related complex (ARC) needed to obtain benefits for services received by me or my dependents, I also authorize release of the above information to clinical and toxicology laboratories so they may bill third payer directly for their services.

Signature: _____ **Relationship:** _____ **Date:** _____

*** If you have any questions or information changes, please call Registration at 517-237-7140 (M-F 8a-5p)**

*** Email this completed form to: ReimbursementRegistration@ceicmh.org**