COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information for Benefits Eligibility Inquiry and/or Reimbursement for Services

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

I authorize the Department of Mental Health (DMH) to contact, as specified below, all federal and state agencies that offer benefits, and private third party insurance carriers, to determine the coverage and/or benefits for which I am eligible. I authorize all such agencies and third parties to release this information to DMH. In addition, I authorize DMH to bill such agencies or third parties for services for which DMH has assessed a charge.

DMH Contact Information:

Name: Phone:

Address:

1. I authorize DMH to request, and for third parties to provide, any and all information relative to my eligibility for public or private financial and/or medical benefits.
2. I authorize DMH to apply for any public or private benefits on my behalf for which I may be eligible.
3. I authorize DMH to bill any public agency or private third party and to release, for this purpose, that amount of protected health information that is required by the public agency or private third party, and to apply monies received to the cost of my care and treatment.
4. I authorize DMH, if appropriate, to appeal on my behalf a denial of benefits or reimbursement for my care and treatment and to release all information pertinent and necessary to the appeal.
5. If DMH refers me to another healthcare provider, I authorize DMH to release such protected health information as is necessary, to allow such provider or its agent(s) to bill for my care and treatment.
6. A copy of this authorization shall be considered as valid as the original.
7. Additional comments/instructions (be specific):_____
_____
_____
_____
_____
_____

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Authorization for Release of Information for Benefits Eligibility Inquiry and/or Reimbursement for Services (continued)

Name of Individual:_____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at the DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company, or third party payer, when the law provides my insurer, or other third party payer, with the right to contest a claim. This authorization will expire_____ (specify a date, time period, or an event), or if nothing is specified, this authorization will expire when I am no longer receiving services from DMH and the billing process, including appeals for services which I received from DMH, has been completed.

I understand that once the above information is disclosed, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified is voluntary. I need not sign this form to receive treatment or services from DMH.

_____ _____
Your signature or Personal Representative's signature Date

_____
Print name of signer

FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) _____

INSTRUCTIONS:

1. This form must be completed in full to be considered valid

2. Distribution of copies: original to appropriate DMH record; copy to individual or Personal Representative; copy(ies) to non-DMH entity(ies).