Medicaid Application

Coverage & Insurance Verification

Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medicaid I.D.: _____ Social Security Number: _____

Home Phone: _____

Cell Phone: _____

E-mail Address: _____

When your application is approved what is your preferred method of contact?

_____

Which of our services are you interested in/applying for?

_____

You application must be authorized by Medicaid prior to any treatment being completed and/or any billing being submitted for treatment. Any lapse in payment by Medicaid will become the full responsibility of the patient.