



**C.A.S.E., inc.**

COMPREHENSIVE AUTISM  
SERVICES & EDUCATION

45-934 KAMEHAMEHA HWY. SUITE C-190

KANEOHE, HI 96744

OFFICE: (808) 779-8883

KIMEEMARTINEZ@CASEFAMILY.COM

WWW.CASEFAMILY.COM

Dear Parents,

Below are the steps needed to get a pre-authorization for Friends' Club services from your insurance company.

**Please note:** We may not be authorized to perform service with every insurance company and or plan but C.A.S.E., Inc. is going to try their best to get you authorized. ***One last thing, it is best to get a pre-authorization before attending any Friends' Club sessions as you are responsible for the fees if your insurance company will not cover the service.***

### **Step 1: Get a referral note from a primary doctor**

Most insurance companies will not give a pre-authorization without a referral from your primary care physician. This means your internal medicine doctor; pediatrician or primary care physician will have to fax or mail in a request to your insurance company stating that they would like C.A.S.E., Inc. to perform group therapy with your child/teen. Below is an example letter:

To Whom It May Concern:

I, Dr. Sher Lippert, M.D., am requesting that C.A.S.E., Inc. perform group therapy for Evan Lyon at their offices.

Thank you,  
Sher Lippert, M.D.

### **Step 2: Fill out an insurance intake form and HCFA form**

The insurance intake form and HCFA need to be filled out so that we have all personal information needed on your child/teen to bill insurance.

*\*\*Both forms are attached to this packet.*

### **Step 3: Copy your insurance card**

Please give C.A.S.E., Inc. a copy of your child's insurance card (front and back). The front will give us your child's member ID and the back of the card will tell us where to mail claims as well as give us a provider help line number. We will also need this for our records.

Thank you for your cooperation in this matter. Your help makes it possible for us to work with your insurance company. If you have any questions, please contact me at (760) 720-4964.

Thank you,

Maria Lyon  
Insurance Liaison  
Comprehensive Autism Services and Education, Inc.



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## Insurance Questionnaire

- 1) Name of patient/client: \_\_\_\_\_
- 2) Name of insured: \_\_\_\_\_
- 3) Medical Insurance Company: \_\_\_\_\_
- 4) SSN of Patient/Client: \_\_\_\_\_
- 5) Home Address: \_\_\_\_\_
- 6) Home Phone Number: \_\_\_\_\_
- 7) SSN of Insured: \_\_\_\_\_
- 8) Insured's Employer: \_\_\_\_\_
- 9) Employer's Address: \_\_\_\_\_
- 10) Type of Coverage: PPO or HMO (circle one)
- 11) Co-pay: \_\_\_\_\_
- 12) Family Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_
- 13) Referring Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_
- 14) Did you include a copy of your insurance card (front and Back)? Yes / No (circle one)  
 We would be happy to make a copy of your insurance card in our office.  
 If you answered "No", please provide claim administrator address and group #.  
 Administrator Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Subscriber/Member #: \_\_\_\_\_

**\*\*Patient and/or Parent or Guardian is responsible for amount not covered by insurance.**

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Signature of Patient  
(If over 18 years of age)

\_\_\_\_\_  
\_\_\_\_\_  
Signature of Parent/Guardian  
(If patient under 18 years of age)



PLEASE  
 DO NOT  
 STAPLE  
 IN THIS  
 AREA

CARRIED

HEALTH INSURANCE CLAIM FORM																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY																								
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																								
CITY STATE					7. INSURED'S ADDRESS (No., Street)																								
CITY STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																								
ZIP CODE TELEPHONE (Include Area Code)					9. PATIENT'S CONDITION RELATED TO:																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:																								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																								
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO																								
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																								
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE																								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																								
SIGNED DATE					SIGNED																								
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																								
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																								
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																								
23. PRIOR AUTHORIZATION NUMBER																													
24. TABLE																													
A		B		C		D		E		F		G		H		I		J		K									
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS EPSDT OR Family Plan		EMG		COB		RESERVED FOR LOCAL USE											
From	To																												
MM	DD	YY	MM	DD	YY																								
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER SBN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																			
SIGNED DATE					PIN#					GRP#																			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION