

The *Hair* Mama

-MEDICAL-

Thank you for using Hair Mama Medical Consulting. We work hard to provide the highest quality care for you. We will attempt to verify that your coverage is valid at the time of your application. We view your insurance coverage as a contract between the insurance company and our client, with HairMama as the liaison. After verifying the benefits with you, our client, we will start the process. We will file with your insurance company to get a pre-approval. Once they have fully approved you for a Medical wig we will schedule you for your Hair Mama Consultation.

Please contact

Vicki Brown

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We are pleased to announce the expansion of (The Hair Mama) into Healthcare Insurance Filing. We now offer our clients the service of filing their insurance claim directly with their insurance carrier. Most insurance companies cover some or all of the expense for a medical wig or medical topper. The process is simple and convenient. The following explains the procedure. .

1. We will require a copy of your prescription including any medical records that you may have.
2. We will need a copy of the front and back of your insurance card.
3. We will need a copy of your Drivers License.

Our secured E-Fax is: 940-535-7337

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (cell or work) _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F

Marital Status: Married Single Divorced Widowed

Employer: _____

Employment status: _____
 Full time Part time Unemployed
 Retired Student Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to Revivify Medical Wig Solution permission to check my insurance benefit, for a Cranial Hair Scalp Prosthesis.

Name(s): _____ Relationship to Patient: _____

Patient / Parent or Guardian Signature: _____ Date: _____

Authorization for Assignment of Benefits and Release of Information:

I hereby authorize and direct payment of my medical benefits to Hair Mama for any services furnished to me by any stylist at Hair Mama. I authorize my stylist to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical services to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including fees for collection services needed.

Signature _____ Date _____

Authorization of Payments

I understand that Hair Mama and Revivify Revenue Cycle Consulting LLC will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Hair Mama for medical benefits, otherwise payable to me for services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services.

Signature _____ Date _____