

*Platte County Health Department*

*Today's Date* \_\_\_\_\_

*Legal Name:*

*First* \_\_\_\_\_ *M.I.* \_\_\_\_\_ *Last* \_\_\_\_\_

*Date of Birth* \_\_\_\_\_ *Age* \_\_\_\_\_ *Sex* \_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Phone Number (816)* \_\_\_\_\_

*Parent/Guardian Name* \_\_\_\_\_

*Parent/Guardian Date of Birth* \_\_\_\_\_

*Medicaid Insurance Plan Name: (Please Circle)*

*Aetna - Missouri Care - Home State Health Plan - Medicaid*

*Medicaid Number* \_\_\_\_\_

**Assignment on Insurance Benefits/Release of Medical Information:**

*I hereby authorize treatment deemed necessary by the Platte County Health Department Provider. I also authorize the release of my medical records to any company to which I have applied for coverage. I request payment of medical insurance benefits to include major medical to be made directly to Platte County Health Department on any unpaid bills for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance if applicable.*

*Signature* \_\_\_\_\_

*Date* \_\_\_\_\_

**WIC STAFF ONLY:**

Office Visit \_\_\_\_\_ 99211

Hemoglobin Check \_\_\_\_\_ 85018

\_\_\_\_\_ Z02.89

Pregnant Woman \_\_\_\_\_

Post Partum \_\_\_\_\_

Breastfeeding \_\_\_\_\_

Child Age \_\_\_\_\_

**Parkville** \_\_\_\_\_

**Platte City** \_\_\_\_\_