PO Box 605 Fitzwilliam NH 03447
O: 603-674-7198   F: 978-297-6534
www.stmbilling.com

Exhibit B

Verification of Benefits Request Form

Welcome to STM Billing! We will be assisting your midwife in insurance billing for your care. Please submit this form **fully completed,** along with the following items so we can open an account for you. **IF THIS REPORT IS RECEIVED INCOMPLETE OR MISSING THE FOLLOWING ITEMS, IT WILL BE DISCARDED. If the ID and insurance card are in the midwife's EHR and we have access check here: ❑**

- a copy of the front your government issued ID
- a copy of the front **and back** of any insurance card(s) you may have

Please submit the above items to: STM Billing's email: anaturalbirth@hotmail.com or fax (above)

We will prepare your report and send it to your midwife to go over with you. Turn around time is typically 1-3 business days.

Please note that there will be a _____% charge from your midwife on any amount received as a reimbursement from your insurance company.

Date of this request:___________________________

About You (the patient)

Your midwife/midwifery practice's name: ____

Your due date (if applicable): ___________________________ Is this your first pregnancy? ❑Yes ❑No

Your name (First, Middle and Last):____

Address: ____

City: ____ State: ____________ Zip: __________________

Home Phone: (   ) ______________________ Work Phone: (   ) _______________________

Cell phone: (   ) ________________________ Your Email: ____________________________________

Social Security Number: ____________ - __________ - _________________ DOB: _____/_____/________

Has the patient already had at least one appointment with the midwife? ❑Yes ❑No
If yes, would you like us to automatically apply for a gap exception if it is applicable? ❑Yes ❑No
If yes, please include demographic sheet and prenatal flow sheet from chart or verify that we have access to the midwife's EHR.

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About Insured (if other than the patient)

Insured's name :____

Insured's Relationship to you:____

Insured's address (if different from the patient):

____

City: ____ State: __________ Zip: ________________

Home Phone: (   ) __________________ Work Phone: (   ) ___________________

Cell phone: (   ) ____________________ Email: ___________________________________

Insured's Social Security Number: _____ - _____ - ________ Insured's DOB: _____/_____/________

Primary Insurace Company:____

Claims Submission Address:____

Provider Services Phone:_________________________________ Medicaid Plan? ❑Yes ❑No

ID# on Card:_________________________________Policy/Group#:_________________________

Secondary Insurace Company:____

Claims Submission Address:____

Provider Services Phone:_________________________________ Medicaid Plan? ❑Yes ❑No

ID# on Card:_________________________________Policy/Group#:_________________________

Tertiary Insurace Company:____

Claims Submission Address:____

Provider Services Phone:_________________________________ Medicaid Plan? ❑Yes ❑No

ID# on Card:_________________________________Policy/Group#:_________________________