BOBBY BENSON CENTER
56-660 Kamehameha Highway, Kahuku, HI 96731
Phone (808) 293-7555 Fax (808) 293-7196
bobbybenson.org

Client Name: **DOB:** **DOA: __/__/____**

HEALTH AND DENTAL INSURANCE FORM, 1 of 2

INSTRUCTIONS*:*

ATTACH A COPY OF THE FRONT OF (Please do not copy on the same page as any other documents (ie Social Security Card and/or Birth Certificate):

❑ ***HEALTH INSURANCE CARD***

❑ ***DENTAL INSURANCE CARD,*** *or* ❑ *Check if same as health insurance*)

- *If the Client has more than one type of health insurance, make an additional copy of PART 1 of this form (page 1 of 2), and complete for any secondary health insurance.*
- *Similarly, if the Client has more than one type of dental insurance, make an additional copy of page 2 of 2, and complete for any secondary dental insurance.*

PART 1: HEALTH INSURANCE COVERAGE VERIFICATION

1. What **type of Health Insurance** does the Client have?
   ☐ HMSA ☐ UHA ☐ Aloha Care ☐ Ohana Health ☐ Kaiser ☐ Other: _____
2. Is this the Client's **primary or secondary** health insurance? ☐ Primary ☐ Secondary
3. Is this a **Quest Policy?** ☐ Yes ☐ No
4. This **policy covers**: ☐ Medical Only ☐ Medical & Dental
5. Who is the "**Subscriber**" or "**Member**" on the insurance card? _____
6. How is the Subscriber/Member **related to the client**?
   ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian, describe: _____
7. What is the "**Subscriber/Member Identification Number"**? _____

Instructions: PLEASE CALL HEALTH INSURANCE COMPANY, and ask the following questions:

8. If client will be using this insurance to fund his/her treatment at Bobby Benson Center, does policy **cover "Residential Substance Abuse Treatment"**? ☐ Yes ☐ No ☐ N/A
9. Is there any **"Unmet Deductible"**? ☐ Yes. How much is it? _____ ☐ No
10. For routine healthcare, is there a **"Co-Pay"?** ☐ Yes. How much is it? _____ ☐ No
11. Who is **responsible to pay** the deductibles and co-pays? _____

    Mailing address? _____ Phone number? _____

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Client Name: **DOB:** **DOA: __/__/____**

HEALTH AND DENTAL INSURANCE FORM, 2 of 2

PART 2: DENTAL INSURANCE COVERAGE VERIFICATION

1. What **type of Dental Insurance** does the Client have? _____
2. Is this the Client's **primary or secondary** dental insurance? ☐ Primary ☐ Secondary
3. Who is the "**Subscriber**" or "**Member**" on the insurance card? _____
4. How is the Subscriber/Member **related to the client**?
   ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian, describe: _____
5. What is the "**Subscriber/Member Identification Number"**? _____
6. What is the Subscriber/Member's **Date of Birth**? _____

PART 3: RELEASE OF LIABILITY FOR MEDICAL/DENTAL COSTS (For Non-CAMHD Funding Only)

As the Parent(s)/Legal Guardian(s) of the above named Client, I understand that health and/or dental insurance may not cover all medical and/or dental expenses necessary to provide the best possible care while my dependent is residing at Bobby Benson Center (BBC). By signing below, I hereby release BBC of all liability for medical and/or dental expenses incurred but not covered by my dependent's health and/or dental insurance; I will assume sole responsibility for such expenses. To discuss billing issues, I give consent for medical and/or dental offices providing care to my dependent to reach me at the contact information I have provided to BBC.

_____ x_____
Print Parent/Legal Guardian Name (Relationship) Signature of Parent/Legal Guardian Date

Andrea Nakashima (Intake Coordinator) x_____
Print Witness Name Signature of Witness Date

BBC Office Use Only
Benefit Level _____ Unmet Deductible _____ Co-Pay Ratio _____ Co-Pay Max _____
Spoke to _____ BBC Staff _____ Date _____
Comments:
_____