KISMET COUNSELING LLC

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Medicaid Eligibility Form

Please complete the following information regarding your Medicaid insurance coverage. Please directly send completed copy to my billing representative via email**: SK Billing, # 844-380-4836 office, skmbilling@yahoo.com**

Please complete the information below:

Today's date: ___________________________

Primary insurance holder name ___________________________

Name of member seeking counseling services ___________________________

Name of insurance ___________________________

Member ID # _____________

Date of Birth of both primary holder and person seeking services _____________

Address______________________________ Phone# ___________________________

City, State, Zip ______________________________ Email ___________________________

*****************The following is for office use only (you do not need to complete) ************

CPT code requesting ___________________________

Diagnosis code ___________________________