

PO Box 155

1601 Broadway

Dakota City, NE 68731

**Phone**: 402-987-2164

**Fax**: 402-987-2163

**Email**: HealthDeptPIO@dakotacountyne.org

**Dakota County Health Department**

**Client Intake/ Release of Information Form**

No VFC child (0-18) will be denied service do inability to pay.

Person Receiving Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MI

First Name

Last Name

Address: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11-digit code

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan (Check Below):

|  |  |
| --- | --- |
|  | Nebraska Medicaid |
|  | Healthy Blue |
|  | Total Care of NE |
|  | United Healthcare-Community Plan |

The Dakota County Health Department (DCHD) provides programs on behalf of the Nebraska Department of Health and Human Services (NE DHHS). Also, some DCHD programs bill NE DHHS Medicaid for services provided. If this occurs, the DCHD is a business associate of NE DHHS and we may be required to share health information with these parties for necessary health care operations.

I authorize the release of medical information necessary to bill my designated insurance company, and request payment of benefits to Dakota County Health Department (DCHD).

**Responsible Party Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_