PO Box 605 Fitzwilliam NH 03447
O: 833-BILL4US 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: stmbilling4us@gmail.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 Insurance Company:_____**

Claims Submission Address:_____

Provider Services Phone:_____ Medicaid Plan? ☐Yes ☐No

ID# on Card:_____Policy/Group#:_____

**Secondary Insurance Company:_____**

Claims Submission Address:_____

Provider Services Phone:_____ Medicaid Plan? ☐Yes ☐No

ID# on Card:_____Policy/Group#:_____

**Tertiary Insurance Company:_____**

Claims Submission Address:_____

Provider Services Phone:_____ Medicaid Plan? ☐Yes ☐No

ID# on Card:_____Policy/Group#:_____