REIMBURSEMENT REQUEST FORM

<table>
<tr><td rowspan="5">Service Codes:
90837 – Individual Psychotherapy
90847 – Family Psychotherapy
H2017 – Behavioral Health Rehabilitation
T1017 – Case Management</td><td colspan="2">Client Name:</td><td>DOB:</td></tr>
<tr><td colspan="2">Date of Service:</td><td>Service Code:</td></tr>
<tr><td>Start Time:</td><td>End Time:</td><td>Provider SSN:</td></tr>
<tr><td colspan="3">Clinician Name:</td></tr>
<tr><td colspan="3">Clinician Agency:</td></tr>
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Treatments / Goals Performed:

- ☐ Skill Development
- ☐ Assisting with Financial Problems
- ☐ Short-term therapy: support dealing with depression/adjustment/management
- ☐ Short-term therapy: strengthen family support system to maximize pt's response to tx
- ☐ Crisis intervention
- ☐ Counseling for long range planning
- ☐ Serving as advocate for services for pt./family
- ☐ Community referral & linkages
- ☐ Teaching pt./family re: options & access to services

COMMENTS: ____

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Payment should be made to: ____

Address: ____

City: ____________________ State: __________ Zip Code: __________

Have you previously received reimbursement from Improving Lives Now? If yes indicate date No Yes ___________

Signature ______________________________________ Date ____________________

Included copy of completed release form
Included copy of Medicaid application status

***Payments are distributed when funds are available. Priority is given to first time applicants**

Reimbursement forms may be mailed or faxed to:

Improving Lives Now
6216 S. Lewis Ave. Ste. 180
Tulsa, OK 74136
(539) 664-5738

FOR OFFICE USE ONLY:

Reimbursement: Approved Denied Marked for Later Consideration

By:______________________ Date: __________ Amount: $_______ Check Number: __________

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____

Date of Birth:_______________________________ Social Security #:_________________________

I hereby authorize ____
Name of Person/Organization Disclosing PHI

to release the following information to **Improving Lives Now**

Information to be shared:

☐ Billing Information
☐ Mental Health Records
☐ Other: ____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☒ Other: Reimbursement of services and reporting purposes

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:____

____

_______________________________________ _______________________________________
Signature of Patient or Legal Representative Date

_______________________________________ _______________________________________
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)