Early Intervention Central Billing Office
Provider Billing Information Release Form

Provider or Payee Name _____
(Type or print Agency or individual as listed on credential)

Taxpayer ID _____
(FEIN or Social Security Number)

Billing Agent Name(s) _____

_____

_____

By signature below, I hereby authorize the Early Intervention Central Billing Office and CQuest America staff or it's designee to release any information necessary to the above entity specified for the purpose of providing technical assistance, and/or processing or correcting claims billed on my behalf. I understand that information on my claims that maybe disclosed is protected under the Health Insurance Portability and Accountability Act of 1996.

☐ Release information to the above billing agent only on claims billed in the following date range
_____/_____/_____ (mm/dd/yy) through _____/_____/_____ (mm/dd/yy)

☐ Release information to the above billing agent on any claims billed by or for me.

I understand this authorization will remain active on file at the Early Intervention Central Billing Office and CQuest America indefinitely and it is my responsibility to contact them immediately should my billing agent change. I understand I may revoke this authorization at any time by contacting The Early Intervention Central Billing Office.

Provider Signature _____

Payee Representative Signature _____

Date Signed _____

A PHOTOCOPY OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.

Fax to: Early Intervention Central Billing Office (217)-541-7475