Western Plains
PUBLIC HEALTH

3rd Party Authorization to Bill for Services

We _____ (*Business Name*) agree to pay for services provided to _____ (*Client Name*) for the purpose of work related requirements or benefits as listed below.
(attach additional sheets if necessary)

Service Approved to Bill: ***(Please check all that apply.)***

☐ TB Test ☐ Flu Vaccine ☐ Immunizations (please list) _____

Other _____

By signing this form you are agreeing to pay for the above services and the person(s) insurance will not be billed. Service cost is subject to change and payment will be requested following administration of each service. Contact Western Plains Public Health for cost of services.

_____
Signature of Authorized Representative

_____
Printed Name

_____
Date

_____
Bill To

_____
Billing Address

_____
Phone Number

Please send this signed authorization form with the client to their scheduled appointment at Western Plains Public Health to prevent the client from being billed for the service. This form must be signed and sent with client for each service rendered on separate days.

This form is invalid 30 days after the date printed above.

Thank you for choosing
Western Plains Public Health

403 Burlington Street SE
Mandan, ND 58554
Phone: 701-667-3370 Fax: 701-667-3371 Toll Free: 888-667-3370
www.westernplainsph.org