



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***
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