



*For Internal Use Only*  
*Date of Completed Application*

Duck # \_\_\_\_\_

***Consent to Bill Medicaid***

I hereby authorize Gateways Community Services to use or disclose health information that may be required to process a claim for payment of benefits. These benefits will be made payable to Gateways Community Services.

Individual's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

MCO:  NH Healthy Families       Wellsense

Signature of Applicant/Guardian: \_\_\_\_\_