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: ☐ AmeriHealth Caritas NH ☐ NH Healthy Families ☐ Wellsense

Signature of Applicant/Guardian: _____