Medicaid Claims Authorization

Resident Name: _____

Resident Medicaid Number: _____

Resident DOB: _____

Facility: _____

1. I authorize the dental care provider or designated staff to perform certain dental procedures as necessary.

2. I authorize Sterling Medicaid Services, LLC to file claims with the corresponding Medicaid agency for services rendered.

3. HIPAA COMPLIANT: the dental care provider and designated staff agree to comply with the Health Insurance Portability and Accountability Act of 1996, “HIPAA” and to maintain the confidentiality of individually identifiable health information of the resident patients provided by the facility.

Self / Responsible Party
Authorized Person’s Signature _____

Print Name: _____

Date: _____

Sterling Medicaid Services, LLC
PO Box 891330, Oklahoma City, OK 73189-1330