



Serving:
 Buncombe, Henderson, Madison,
 Mitchell, Rutherford, Polk,
 Transylvania and Yancey Counties

Western Highlands Medicaid Enrollee Registration Form (MERF)
For Unmanaged Basic Benefit Consumers
and Medicaid Consumers admitted to Hospitals

- Unmanaged Basic Benefit**
- Hospital Inpatient**

To be completed during the first face-to-face meeting when it is determined that consumer will be receiving services with this provider. The purpose of this form is to register Medicaid consumers with Western Highlands while in unmanaged basic benefit services or while accessing hospital beds, and for the release of information regarding eligibility for services. This form **must be submitted to Western Highlands Network (WHN) in order for providers to bill Western Highlands.** This form does **not** constitute consent for treatment, which **must** be obtained by the **new** provider before services are delivered.

PLEASE TYPE OR LEGIBLY PRINT INFORMATION

Consumer's Legal Last Name Legal First Name Middle Initial **Maiden Name** (Required for female consumers)

____/____/____ ____/____/____
 Consumer's Date of Birth Consumer's Social Security #

____/____/____ _____
 Date of Consumer's First Receipt Consumer Medicaid Number
 of a Service

Consumer Medicaid County	Mark with X	COUNTY	Mark with X
Buncombe	<input type="checkbox"/>	Henderson	<input type="checkbox"/>
Madison	<input type="checkbox"/>	Mitchell	<input type="checkbox"/>
Polk	<input type="checkbox"/>	Rutherford	<input type="checkbox"/>
Transylvania	<input type="checkbox"/>	Yancey	<input type="checkbox"/>

I, _____
 Consumer or *Guardian* (if consumer is less than 18 y/o)

request that my services/supports be provided by:

New Provider/Agency Name **New Provider Email address:**
 (*Note: The WHN consumer ID number will be emailed to you for billing purposes)

Authorization of Release

CONSUMER: I hereby authorize Western Highlands Network to disclose/release/share information with the provider listed above including information related to alcohol and/or drug abuse information according to Federal regulations (42 CFR Part 2) and/or information regarding communicable diseases in addition to the names of previous treatment agencies. I hereby authorize Western Highlands Network to advise my previous provider with information from and/or a copy of this form. This form does not constitute Consent for the Release of Information from the records of other providers.

I understand that this does **not** prohibit me from transferring providers through Western Highlands Network in the future.

 Consumer Signature (Guardian if consumer is under 18 years old)

 Date:

 Witness Signature (if client's signature necessary, CMS requirement for hospital use only)

 Date: Time:

 Clinician and title (print & sign)

 Date:

 Provider/ Agency Name (please print)

 Provider Phone #

Fax to: **828-225-2797** or mail to: Western Highlands Network – Access/UM
 356 Biltmore Avenue
 Asheville, NC 28801