

ONE TIME AUTHORIZATION

In order to submit a claim for payment directly to your provider for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE PATIENTS ONLY

Name of beneficiary (Self): _____

MEDICARE # _____

I request that payment of Medicare benefits be made either to me or on my behalf to the above named provider of services for any services furnished to me by provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents the information needed to determine these benefits of the related services.

I hereby authorize Medicare to furnish to the above named physician any information regarding any Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the physician indicated on the claim.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

A copy of this signature is as valid as the original.

Patient/Patient Representative Signature

Date

PLEASE GIVE COMPLETED FORM TO THE RECEPTIONIST