

**CLAIM AUTHORIZATION FOR MEDICARE PATIENTS
OR OTHER HEALTH INSURANCE**

HEALTH INSURANCE COMPANY

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically-related facility to furnish any and all records, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to the health insurer.

I also authorize the insurer to disclose to a hospital or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with the insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors, and administrators."

MEDICARE

"I understand that payment of authorized Medicare benefits are made on my behalf to this office for any services furnished to me by one of the practice physicians. I understand further that I am responsible to pay this practice directly for my co-insurance and annual deductible. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

AUTHORIZATION TO PAY:

"I authorize insurance claim payments to be sent directly to the physician or supplier for the services described."

PATIENT'S RESPONSIBILITY TO PAY:

"I agree that I am solely responsible to pay all fees charged by the Doctor, regardless of how much my insurance pays. For Medicare and other participating programs, the respective rules and regulations of each prevail.