

# INSURANCE PAYMENT AUTHORIZATION



## FOR MEDICARE RECIPIENTS

I request that payment of authorized Medicare benefits be made directly to the doctor for any services furnished to me. 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. If other health insurance is indicated in item 9 of the HCFA-1500 form or electronically submitted claims, I authorize the release of information to that insurer. **I agree to be responsible for the deductible, coinsurance and noncovered services as determined by the Medicare carrier.**

## FOR INDEMNITY, PPO OR HMO PLAN HOLDERS

Your health benefit plan is an agreement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may be participants in the plan, your health benefit plan determines your coverage for medical services.

**You agree to accept financial responsibility for Co-Payments, Deductibles, Medical Care and Other Services that are provided to you which are not specifically covered by your health benefit plan or not covered due to absence of any authorizations or referrals you are obligated to obtain, prior to seeing the doctor as stated under your health benefit plan.** The services, plans and benefits under your health plan may be subject to and governed by applicable contracts and government regulations. This agreement is not intended to conflict with or circumvent the provisions of such contracts and regulations, including, any provisions regarding grievance procedures that may be available to you.

I hereby agree to the above and authorize my insurer to pay directly to the doctor, benefits due out of indemnity under the terms of my policy issued by that company. Payment is authorized upon receipt of his itemized statement for services rendered to me.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_