INSURANCE AUTHORIZATION FORM

PATIENT ACCOUNT NUMBER PATIENT NAME

_____MEDICARE HIC NUMBER_____

Statement to Permit Payment of Medicare Benefits to Provider, Physician's and Patient

I request payment of authorized Medicare Benefits to me or in my behalf for any services furnished to me by St. Luke's Health Services. I authorize any holder of medical and other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed to determine benefits or benefits for related services. I understand that I am responsible for any health insurance deductibles, co-insurances or other non-covered services.

_____ _____

Date Signature- Beneficiary

_____ _____

Date Other Signature

_____

Relationship and Reason

_____MEDIGAP HIC NUMBER_____

MEDIGAP POLICY NUMBER_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to _____any information needed to determine these benefits payable for related services. (Name of Medigap Insurer)

_____ _____

Date Signature- Beneficiary

_____ _____

Date Other Signature

_____

Relationship and Reason

_____MEDICAL ASSISTANCE RECIPIENT NUMBER_____

"My signature certifies that I received a service or item on the date listed below. I understand that payment for services or items will be from Federal and State Funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State Laws.

I have read and agree with the above statement."

_____ _____

Date Signature

_____WORKER'S COMPENSATION _____AUTO _____COMMERCIAL

Authorization to Release Medical Information- "I authorize St. Luke's Health Services to release any information required to complete my compensation, auto and/or insurance claim to my employer/insurance company pertaining to my visit(s) of _____.

_____ _____

Date Signature

Assignment of Insurance Benefits- "I hereby assign to St. Luke's Health Services (SLHS) and authorize and direct that payment be made directly to SLHS, of all benefits otherwise payable to me directly under the terms of my insurance policies (including major medical) by reason of the services described in the statements rendered by SLHS; provide that SLHS shall refund to the persons or persons entitled to receive the same, any payments in excess of its full charges. I understand that I am financially responsible for all charges not covered by this assignment"

_____ _____

Date Signature