INSURANCE INFORMATION

The name the insurance is under.

Last Name _____ **First** _____ **Initial** _____

Address (if different) _____

City _____ **State** _____ **Zip** _____

Birthdate _____ **SS#**_____ - _____ - _____ **Home Phone** _____

Person Responsible Employed By _____ **Business Phone** _____

Insurance Company (Primary) _____

Contract # _____

Group # _____

Subscriber ID # _____

Insurance Company (Secondary) _____

Contract # _____

Group # _____

Subscriber ID # _____

AUTHORIZATIONS

I, the undersigned, have insurance coverage with _____ **and assign directly to SNYDER EYE GROUP, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.**

Signed _____ **Date** _____

MEDICAL AUTHORIZATIONS

I request that payments of authorized Medicare benefits be made to either me or on my behalf to SNYDER EYE GROUP for any and all services furnished me by that physician. 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 benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicate assigned cases, the physician or supplier aggress to accept the charge determination of the Medicare carrier as the full charge and that patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ **Date** _____