

**AUTHORIZATION TO PAY BENEFITS AND RELEASE MEDICAL
INFORMATION TO THE ANDERSON CLINIC, INC.**

I, _____, Hereby authorize The Anderson Clinic, Inc. to apply for benefits for covered services rendered and request payments from Medicare, BC/BS of the National Capital Area, Medigap and/or _____ be made directly to the Anderson Clinic, Inc.

I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claim, to the above named billing agent, BC/BS of the National Capital area, Medigap, _____ or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Finance Administration or Trailblazers Medicare.

Workers comp cases will be billed to their respected Workers Comp carrier. However, if denied, the patient becomes responsible for payment.

I further understand that I am responsible for all outstanding balances, fees and finance charges for the patient regardless of insurance coverage. If the account is placed with a collection agency or attorney, the undersigned agrees to pay 25% in addition to the outstanding unpaid balance as a reasonable collection fee, together with additional cost/expenses of collections to the present extent of the law. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me, in writing, at any time.

I hereby state that I have read and fully understand the above.

Signature

Printed Name

Date

FILL OUT THE BELOW ONLY IF YOU HAVE MEDICARE:

Please update my records to reflect the following information:

Are you currently employed? YES NO

If yes, are there more than 20 employees in your company? YES NO

If retired, effective date of retirement Month _____ Day ____ Year _____

Is your spouse currently employed? YES NO

If yes, are there more than 20 employees in the company? YES NO

If retired, effective date of retirement: Month _____ Day ____ Year _____

Are you or your spouse covered under any insurance plan through a current employer? Y N

If retired, were you or your spouse covered under any other insurance plan while employed? Y N

*IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS,
PLEASE COMPLETE THE FOLLOWING:*

SPOUSE'S Name: _____ Date of Birth: ____/____/____

Name and address of Employer Group Health Plan _____

Is the insurance through a current employer, a retiree program or Medigap plan? _____

Plan ID Number: _____ Group Plan Number: _____

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____