



INSURANCE AUTHORIZATION SIGNATURE ON FILE

You can eliminate the need for the patient to sign every claim form by printing the words "Signature on File" in the appropriate boxes. This authorization from, properly completed and kept on file in your office puts you in compliance with regulations.

Insured _____
(Policyholder) _____
Insured's Date of Birth _____
(Policyholder) _____

Insurance Company Address and Phone

City State Zip

Phone _____

Patient's Insurance Authorization

Patient's Name _____

Insurance Number _____ Group Number _____

I request that payment of authorized Medicare and/or any Insurer benefits be made either to me or on my behalf to: _____ for any services furnished me by that physician/ supplier.

(Doctors Name)

I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents and/or to any Insurer any information needed to determine the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

Signature

Date