Insurance Signature Form

HMO PATIENTS

I AM MEMBER OF COMMUNITY BLUE, BLUCROSS BLUE SHEILD, UNIVERA, INDEPENDENT HEALTH OR AETNA. AMANDEEP PAL, MD IS MY PRIMARY CARE PHYSICIAN AND I AM AWARE I MUST OBTAIN A REFERRAL FROM DR. PAL FIRST BEFORE SEEING A SPECIALIST.

SIGNATURE_____ PRINT NAME_____ DATE_____

MEDICARE PATIENTS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER THE TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFIT PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICAINS OR ORGANIZION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR OGANIZATION TO SUBMIT
A CLAIM TO MEDICARE FOR PAYMENT.

SIGNATURE_____PRINT NAME_____DATE_____

WORKERS COMPENSATION OR NO-FAULT PATIENTS

I HEARBY AUTHORIZE AMANDEEP PAL M.D. TO FURNISH INFORMATION TO MY HEALTH INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT FOR THE PURPOSE OF CLAIM EVALUATIONAND REIMBURSEMENTOF BENEFITS. IASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE COMPANY. A PHOTOCOPY OF THIS ASSIGNMENT WILL BE AS VALID AS THE ORIGINAL.

COMPLETE ADDITIONAL WORKERS COMPENSATION/NO-FAULT FORM

SIGNATURE_____PRINT NAME_____DATE_____