

SIGNATURE ON FILE

Insurance Authorization / Assignment

I authorize the release of any medical or other information necessary to process my insurance claim. My signature authorizes payment of all medical and/or surgical benefits, to which I am entitled to **Bakersfield Neuroscience & Spine Institute**. I understand that I am responsible for charges not covered by my insurance. A photocopy of this document is considered as valid as the original.

Patient Name/ (Print)

Date

Insured's Signature

Subscriber's Number

MEDICARE

Medicare Authorization / Assignment

I request that payment of authorized Medicare benefits are made on my behalf to **Bakersfield Neuroscience & Spine Institute**, for any services furnished me by Bakersfield Neuroscience & Spine Institute. I authorize any holder of medical information about me to the healthcare Financing Administration and its agencies any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim for or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patient Name/ (Print)

Date

Insured's Signature

Patient's Medicare Number

Medigap Assignment of Benefits

I request the payment of authorized Medigap benefits be made either to me or on my behalf to **Bakersfield Neuroscience & Spine Institute** for any services furnished my by Bakersfield Neuroscience & Spine Institute. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Name/ (Print)

Date

Patient's Signature

Medigap Number