Patient's Name ______________________________
(Last) (First) (MI)

Patient No. ______________________________

Site and Department Number ______________________________

INSURANCE AUTHORIZATION

We need this form completed and signed in order to file a claim to your insurer.

MEDICARE LIFETIME AUTHORIZATION

____
(Medicare Number)

I request that payment of authorized Medicare benefits for services furnished by Dean Health Systems, Inc. and/or St. Marys Dean Ventures, Inc., including physician services, be paid on my behalf directly to Dean Health Systems, Inc. and/or St. Marys Dean Ventures, Inc. I authorize any holder of medical information or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine Medicare benefits for medical services rendered to me.

______________________________ ______________________________
Patient Signature Date

ASSIGNMENT OF MEDIGAP BENEFITS

______________________________ ______________________________
(Medigap Policy Number) **(Name of Medigap Payor)**

I authorize the release of information by Dean Health Systems, Inc. and/or St. Marys Dean Ventures, Inc. to the extent that disclosure of my medical records is necessary for billing, collection, or payment of claims. I assign benefits to Dean Health Systems, Inc. and/or St. Marys Dean Ventures, Inc. for charges incurred by eligible persons covered under my current plan. Reimbursement is subject to eligibility and plan limitations.

______________________________ ______________________________
Patient Signature Date

COMMERCIAL ASSIGNMENT OF BENEFITS

____
(Name of Payor)

I authorize the release of information by Dean Health Systems, Inc. and/or St. Marys Dean Ventures, Inc. to the extent that disclosure of my medical records is necessary for billing, collection, or payment of claims. I assign benefits to Dean Health Systems, Inc. and/or St. Marys Dean Ventures, Inc., for charges incurred by eligible persons covered under my current, subsequent and/or new insurance plan. Reimbursement is subject to eligibility and plan limitations. I understand that my insurance is billed as a courtesy in the absence of a participating provider agreement. I acknowledge that I am financially responsible for all charges not covered by insurance.

______________________________ ______________________________
Patient Signature Date

If you carry Medicare and a Medigap/supplemental policy, please sign BOTH applicable authorizations.
If you carry a Private/Commercial insurance policy, please complete the "commercial assignment of benefits" section.
If the patient is under 18 years of age, the parent or guardian should sign this form.

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