Heights Hand Therapy OT
Hand & Upper Extremity Rehabilitation, PLLC

50 Court Street, Suite 1208

Brooklyn, NY 11201

Tel:718-875-4030 / Fax:718-875-6312
heightshandtherapyOT@aol.com

Name of Primary Insurance Company

Primary Policy Holder Name:

Address:
City, State, Zip:
Policy Subscriber Number:

Medicare No: _____
Effective Date Part A: _____
Effective Date Part B: _____
_____Medicaid/HMO
_____Worker's Comp
_____Medicare
_____No Fault

Name of Secondary Insurance Company

Primary Policy Holder Name:

Address:
City, State, Zip
Group Plan:
Medicare No:

Effective Date Part A: _____
Effective Date Part B: _____
_____Medicaid/HMO
_____Worker's Comp
_____Medicare
_____No Fault

Relationship to Patient (If patient is NOT the Policy Holder)_____

Authorization and Release: (*Non Medicare)*

I authorize the release of any of my information including the diagnosis and the records of any treatment or examination, rendered to me or my dependents during the period of such care, to third party payers and other health care practitioners.

I authorize payment of medical benefits made on my behalf directly to Heights Hand Therapy OT, and I understand that I will be responsible for securing the necessary referrals and the payment of any non-covered out of pocket expenses outlined by my policy.

Signature of Patient/Responsible Person or Parent, if minor

Date

Authorization and Release (Medicare Only)

Name of Medicare beneficiary/Patient

Medicare No:

Medigap/Secondary _____

Policy No:

I request that payment of authorized Medicare and/or Medigap insure and/or the Health Care Financing Administration, and to its agents, information needed to determine these benefits ore the benefits payable for related services.

This authorization is valid for all services rendered until it is revoked in writing.

Patient's Signature

Date

Provider's Signature