Addiction Care of Excellence

An Outpatient Medical Recovery Program

Patient Insurance Authorization Form

Patient Name_____ Date of Birth_____ Gender: Male / Female

Address_____

Home Telephone _____ Mobile Telephone _____

Medicare B signature authorization for services starting date: _____

I, _____, am giving Dr. Mark X. Norleans permission to ask for Medicare payments for my medical care. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Health Care Financing Administration (HCFA) is the government Medicare agency. I request that payment of authorized Medicare benefits be made to Dr. Norleans on my behalf for any services furnished to me by Dr. Norleans or in Dr. Norleans' facilities, including physician services. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Patient Signature By – If other than patient

_____ _____

Medicare Claim Number (HICN) Reason – If patient unable to sign

Commercial insurance authorization for services starting date: _____

I, _____, authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Dr. Mark X. Norleans for services rendered.

_____

Patient or authorized person's Signature

If patient is a minor, please complete the following:

I, _____, _____ of

(Full name of responsible party/guarantor) (Relationship to minor)

_____, hereby personally accept financial responsibility for

(Full name of minor)

professional services rendered by Dr. Mark X. Norleans upon the person aforementioned.

_____

Guarantor's Signature

Personal Injury, Vehicle Accident or Worker's Compensation Insurances:

Date of Injury _____ Date of Accident _____

Case Number _____ Insurance Carrier_____

Adjuster Information _____