CONSENT TO FILE INSURANCE/ASSIGNMENT OF BENEFITS

PATIENT NAME: ____
CALL NUMBER: ______________________ DATE OF CALL: ____________
SOCIAL SECURITY #____________________ DATE OF BIRTH____________

PLEASE COMPLETE THIS FORM AND RETURN IT TO OUR OFFICE AS SOON AS POSSIBLE. ALL INFORMATION IS NEEDED TO FILE CLAIMS WITH YOUR INSURANCE CARRIER. PLEASE BE SURE TO SIGN THIS FORM INDICATING YOUR CONSENT TO PAY US DIRECTLY. ***NAMES SHOULD BE EXACTLY AS THEY APPEAR ON YOUR INSURANCE CARD.***

MEDICARE NUMBER: ____
PRIMARY ☐ SECONDARY ☐
MEDICAID NUMBER: ____
PRIMARY ☐ SECONDARY ☐

IF AUTO ACCIDENT GIVE AUTO CARRIER, POLICY NUMBER AND CLAIM NUMBER. USE HEALTH INSURANCE CARRIER AS SECONDARY

PRIMARY INSURANCE:
INSURANCE COMPANY NAME: ______________________________________

ADDRESS: ____

CITY/STATE/ZIP: ____

INSURANCE COMPANY TELEPHONE NUMBER:___________________________

POLICY HOLDER (IF OTHER THAN PATIENT):_____________________________

DATE OF BIRTH: ____________ SOCIAL SECURITY # __________________

GROUP NUMBER: ________________POLICY # ____________________

SECONDARY INSURANCE:
INSURANCE COMPANY NAME: ______________________________________

ADDRESS: ____

CITY/STATE/ ZIP:____

INSURANCE COMPANY TELEPHONE NUMBER: __________________________

POLICY HOLDER (IF OTHER THAN PATIENT): ____________________________

GROUP NUMBER: ________________ POLICY # ____________________

DATE OF BIRTH: ________________SOCIAL SECURITY#:________________

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/MEDICAID/INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO NASSAU COUNTY BOARD OF COUNTY COMMISSIONERS FOR RESCUE SERVICES FURNISHED TO ME BY THAT SUPPLIER. I AUTHORIZE ANY HOLDER OF HOSPITAL OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS AND CARRIERS AS WELL AS TO NASSAU COUNTY BOARD OF COUNTY COMMISSIONERS ANY INFORMATION OR DOCUMENTATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT THIS AUTHORIZATION MAY BE USED BY THE SUPPLIER FOR ALL SERVICES IN THE FUTURE UNTIL SUCH TIME AS I REVOKE THIS AUTHORIZATION IN WRITING.

______________________________________ ____________________
SIGNATURE AND CONSENT TO PAY DIRECTLY DATE