

CLAIMS AUTHORIZATION FOR MEDICARE AND EMPIRE BLUE CROSS AND BLUE SHIELD PATIENTS OR OTHER HEALTH INSURANCE

BLUE SHIELD PLAN OR OTHER INSURANCE:

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to Empire Blue Cross and Blue Shield or other insurer.

I also authorize Empire Blue Cross and Blue Shield or other insurer to disclose to a hospital or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with Empire Blue Cross and Blue Shield or other insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators."

MEDICARE:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

AUTHORIZATION TO PAY:

"I request payment of this claim and, if the payor accepts assignment, authorize payment directly to the physician or supplier for the services described."

"I am in agreement with the authorization to pay statement above.

Insured's Signature

Date Signed