

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

**ORANGETOWN ORTHOPEDIC ASSOCIATES**

**TAX ID 136604358**

**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 Blue Shield or other insurer.

I also authorize Blue Shield or other insurer to disclose to a hospital or health care service plan, self-insurer, or to 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 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 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 payer accepts assignment, authorize payment direct to the physician or supplier for the services described”.

“I verify the accuracy of this information and I authorize the release of information as provided on the reverse side of this form”.

Patient Signature / Date

X \_\_\_\_\_

Patient Signature / Date

“I am in agreement with the authorization to pay statement on this form”.

X \_\_\_\_\_

# PATIENT INFORMATION

FOR OFFICE USE ONLY			
ACCOUNT NUMBER	DATE	TYPE OF ACCOUNT	APPT. WITH DOCTOR

PATIENT INFORMATION			
Name		Marital Status	
Street Address	City	State	Zip Code
Home Phone	Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #	Family Physician Name & Address		
Name of Employer			
Street Address	City	State	Zip Code
Occupation			Business Phone

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR NOT THE INSURED			
Name of Responsible Party/Insured			
Street Address	City	State	Zip Code
Relationship to Patient	Date of Birth	Social Security #	
Name of Their Employer			
Street Address of Employer	City	State	Zip Code      Business Phone

INSURANCE INFORMATION			
Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident	File #	Policy #
Work Related Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident	Carrier Case #	WCB #

GET THIS INFORMATION FROM YOUR INSURANCE ID CARD OR FORM			
Name of Primary Insurance Co.			
	Claims Address	City	State      Zip Code
Insurance ID Number	Group #	Whose Policy Is This?	
Name of Secondary Insurance Co.			
	Claims Address	City	State      Zip Code
Insurance ID Number	Group #	Whose Policy Is This?	