AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS

COMMERCIAL INSURANCE

I hereby authorize treatment of the person named above and agree to pay all fees and charges related for such treatments. I authorize release of all medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to SHEIKH A. LATIF, D.O., P.C. I understand that I am financially responsible for any balance not covered by my insurance carrier.
Signature of patient: _____ Date: _____

MEDICARE INSURANCE

BENEFICIARY _____
MEDICARE NUMBER _____

I request that payment of authorized Medicare benefits be made on my behalf to SHEIKH A. LATIF, D.O., P.C. for any services furnished to me by this provider. I authorize any custodian of medical information about me to release to the Health Care Financing Administration and its agents all information needed to determine these benefits or the benefits payable for related services.
Signature of patient: _____ Date: _____

MEDICARE SUPPLEMENTAL INSURANCE

BENEFICIARY _____
MEDICARE NUMBER _____

I hereby give SHEIKH A. LATIF, D.O., P.C. permission to bill for Medicare Supplemental Insurance payments for my medical care. I understand that (Name of Medicare Supplemental Insurance Carrier) _____ needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to (Name of Medicare Supplemental Insurance Company) _____. I request that payment of authorized Medicare Supplemental benefits be made on my behalf to SHEIKH A. LATIF, D.O., P.C. for any services furnished by this provider. I authorized any holder of medical information about me to release to (Name of Medicare Supplemental Insurance) _____ for any information required to determine and pay benefits.

Beneficiary Signature: _____ Date: _____