Clinton
REGIONAL HOSPITAL
Primary Care
Dr. Nadia Azuero

ASSIGNMENT OF BENEFITS FORM

Patient Name:_____ DOB: _____
Insurance ID#:_____ Group #:_____
Insurance Carrier:_____

I, _____, certify that I (or my dependent) have insurance
Name

Coverage as stated above, authorize the direct payment to Clinton Regional Hospital, of any insurance benefits otherwise payable to me, for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I hereby authorize Clinton Regional Hospital to release all information necessary to secure the payment of benefits.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and authorize payment of my medical benefits directly to Clinton Regional Hospital for services I have received.

MEDICARE/MEDICAID CERTIFICATION (if applicable)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or organization to submit a claim to Medicare/Medicaid for payment.

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FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and services not covered by my insurance. I understand that payment is due at the time of service unless other arrangements have been made in advance.

ASSIGNMENT OF BENEFITS

I hereby assign to Clinton Regional Hospital all payments for medical services rendered to myself or my dependents. I understand this assignment will remain in effect until revoked by me in writing.

ACKNOWLEDGEMENT

I have read and understand the financial policies of Clinton Regional Hospital, as described above. I agree to be bound by these terms. I also understand and agree that such terms may be amended by Clinton Regional Hospital from time to time.

Signature of Patient, Parent or Legal Guardian: _____

Date: _____

Printed Name of Patient, Parent or Legal Guardian: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____