CHARTER RADIOLOGY

PATIENT INFORMATION & BILLING AUTHORIZATION

PATIENT: _____

Last Name First Name Middle Name

_____

Sex Date of Birth MRN

ADDRESS: _____

Street City State Zip Code

PHONE: _____

Home Phone Cell Phone

INSURANCE: _____

Company Policy Number Group Number

_____

Policy Holder DOB

_____

Secondary Policy Number Group Number

_____

Policy Holder DOB

(____) **MEDICARE (initial if you are covered by Medicare)**

I request that payment of authorized Medicare benefit be made to CHARTER RADIOLOGY LLC for any services they furnished 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 to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the Medicare allowed amount. The patient is responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and the deductible are based on the charge determination of Medicare Carrier.

(____) **MEDICAL INSURANCE (initial if you are covered by any medical insurance including, but not limited to, Medigap, Worker's Compensation or Personal Injury Protection benefits/Auto)**

I authorize payment of medical benefits, otherwise payable to me, to CHARTER RADIOLOGY, LLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize Charter Radiology LLC to release to my insurance company any medical information for processing of a claim. I authorize Charter Radiology LLC to obtain information pertaining to my insurance coverage and benefits from the carrier of same. I permit a copy of this authorization to be used in place of the original.

_____

Date **Signature** of patient or parent (if under age 18)

_____

Print full name of responsible party if patient is a minor