



## EYE ASSOCIATES OF WILMINGTON, P.A.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/other Insurance Company benefits be made either to me or on my behalf to EYE ASSOCIATES OF WILMINGTON for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section: 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_