Benacare Medical Center, Inc.

INSURANCE ELIGIBILITY WAIVER
FOR PHYSICIAN & NON-PHYSICIAN SERVICES

Verification of your health plan benefits is not a guarantee of payment. Medical services will be provided to you; however, in the event your coverage is not effective and/or certain services are not covered, you will be held responsible for payment. It is your responsibility to understand your insurance coverage and benefits.

PATIENT'S NAME:		D.O.B.:
PRIMARY INSURANCE CARRIER:		EFFECTIVE DATE:
SUBSCRIBER'S NAME:	SUBSCRIBER'S PHONE NO.:	SUBSCRIBER'S SOCIAL SECURITY NO.:
SUBSCRIBER'S DATE OF BIRTH:	SUBSCRIBER'S EMPLOYER:	SUBSCRIBER'S RELATIONSHIP TO PATIENT:
SECONDARY INSURANCE CARRIER:		EFFECTIVE DATE:
SUBSCRIBER'S NAME:	SUBSCRIBER'S PHONE NO.:	SUBSCRIBER'S SOCIAL SECURITY NO.:
SUBSCRIBER'S DATE OF BIRTH:	SUBSCRIBER'S EMPLOYER:	SUBSCRIBER'S RELATIONSHIP TO PATIENT:

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made payable to Benacare Medical Center, Inc. and It's Associated Providers for any service furnished to me by Benacare Medical Center, Inc. and It's Associated Providers. I authorize release of all medical records needed to determine benefits and process the insurance claims. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

NON-MEDICARE PATIENTS:

I authorize the release of all medical records needed to process this claim that are pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to Benacare Medical Center, Inc. & Its Associated Providers. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I assume financial responsibility for all charges.
I have read the above information and understand it.

Patient's Signature

X_____ _____

(if patient is a minor, a parent's signature is required) Relationship to Patient

X_____ _____

Witness Date