BETH ISRAEL MEDICAL CENTER

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INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE AND DIRECT BETH ISRAEL MEDICAL CENTER TO RELEASE TO GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH HOSPITALIZATION AND MEDICAL CARE AND PERMIT REPRESENTATIVES THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATED TO SUCH CARE AND TREATMENT.

ASSIGNMENT OF BENEFITS

I ALSO HEREBY ASSIGN, TRANSFER, AND SET OVER TO BETH ISRAEL MEDICAL CENTER SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN THIS HOSPITAL.

FINANCIAL AGREEMENT

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE. IF I AM NOT COVERED UNDER ANY INSURANCE POLICY OR PLAN, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED DURING MY HOSPITALIZATION.

PATIENT ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER THE TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO THE PHYSICIAN OR ORGANIZATION PROVIDING THE SERVICES.

PATIENT/RELATIVE OR GUARDIAN:

SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SOCIAL SECURITY NUMBER: _____

HOME ADDRESS _____ PHONE #: _____

BUSINESS NAME _____ PHONE #: _____

BUSINESS ADDRESS: _____