

Marysville Obstetrics & Gynecology, Inc.

**INSURANCE AUTHORIZATION**

I request that payment of authorized Medicare or other medical insurance carriers' benefits be made either to me on my behalf to providers of Marysville Obstetrics and Gynecology, Inc. for any services furnished by that physician. I authorize any holder of medical information about me to release it to the Centers for Medicare and Medicaid (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA – 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer and agency shown. In the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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**Signature of the Insured**

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**Date**

**TURN OVER!!!**