Valley Urological ASSOCIATES

Competence, Compassion...Convenience
Trusted expertise, close to home™

INSURANCE AUTHORIZATION

MEDICARE PATIENTS *(Please read and sign)*

NAME: _____ ID#: _____

I request that payment of authorized Medicare benefits be made on my behalf to Valley Urological Associates for any services furnished to me by that physician group. I authorize any holder of hospital or medical information about me to release to CMS (formerly known as HCFA) and its agents any information needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. This is a lifetime authorization but can be revoked at any time when the request is put forth in writing by myself.

_____ _____
Patient Signature Date

ALL REMAINING INSURANCE COVERAGE *(HMOs, Third Party, Highmark)*

PATIENT NAME: _____

GUARANTOR: _____

NAME OF INSURANCE COMPANY: _____

I hereby authorize Valley Urological Associates to release any information for insurance claims processing acquired in the course of my examination or treatment, and I authorize payment of claims for services rendered, medical or surgical, be paid directly to Valley Urological Associates. I understand I am financially responsible for any and all charges incurred by my treatment and/or surgical procedures and, I further guarantee payment of all oustanding balances on this account.

_____ _____
Signature Date