RETINA-VITREOUS SURGEONS
OF CENTRAL NEW YORK, P.C.

www.rvscny.com

PATIENT NAME _____ **DATE OF BIRTH** _____
(FIRST) (MIDDLE INITIAL) (LAST)

PRIMARY INSURANCE INFORMATION

INSURANCE CARRIER _____ **PHONE** _____

ID# _____ **GROUP #** _____

IF THE SUBSCRIBER IS DIFFERENT FROM THE PATIENT:

SUBSCRIBER'S NAME _____ **DATE OF BIRTH** _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE

INSURANCE CARRIER _____ **PHONE**_____

ID # _____**GROUP #** _____

IF THE SUBSCRIBER'S NAME IS DIFFERENT FROM THE PATIENT:

SUBSCRIBER'S NAME _____ **DATE OF BIRTH** _____

RELATIONSHIP TO PATIENT _____

IS THE PATIENT IN A SKILLED NURSING FACILITY? O **YES** O **NO**

IF YES, PLEASE GIVE THE NAME OF THE SKILLED NURSING FACILITY _____

IS THIS A WORKER'S COMPENSATION CLAIM? O **YES** O **NO**

IF YES, PLEASE SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK.

MEDICARE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I request that payment of authorized Medicare benefits be made on my behalf to Retina-Vitreous Surgeons of Central NY, P.C. for any services rendered by a physician of the group. I authorize any holder of medical information about me to release to theHealth Care Financing Administration and its agents any information to determine these benefits payable for related services.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I authorize payment of medical benefits to Retina-Vitreous Surgeons of Central NY, P.C. for any services rendered by a physician of the group. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the release to my insurance company or their agent information concerning health care, advice, or treatment provided. This information will be used for the purpose of evaluating and administering claims of benefits.

I have read and completed this document to the best of my ability, and I understand and agree to all the terms and conditions.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

(PRINTED NAME IF LEGAL GUARDIAN) (RELATIONSHIP TO PATIENT)