

## ASSIGNMENT OF BENEFITS

**Medicare** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Main Line HealthCare and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

**In order to comply with Medicare regulations, please answer the following questions:**

|                                                   |                                                       |                                                                     |                                                       |
|---------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------|
| Are you or your spouse employed?                  | <input type="checkbox"/> Y <input type="checkbox"/> N | Has treatment been authorized by the V.A.?                          | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Do you or your spouse have other insurance?       | <input type="checkbox"/> Y <input type="checkbox"/> N | Are you covered under the Black Lung Program?                       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Are you disabled or have end stage renal disease? | <input type="checkbox"/> Y <input type="checkbox"/> N | Is there Medigap coverage secondary to Medicare?                    | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Is illness/injury the result of an auto accident? | <input type="checkbox"/> Y <input type="checkbox"/> N | Is there insurance coverage primary to Medicare?                    | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Did illness/injury occur at work?                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Is there employer supplemental coverage secondary to Medicare?..... | <input type="checkbox"/> Y <input type="checkbox"/> N |

**Medigap (Medicare Secondary Insurance)** I request that payment of authorized Medigap benefits be made either to me or on my behalf to Main Line HealthCare for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to \_\_\_\_\_ (Name of Medigap Coverage) any information needed to determine these benefits payable for related services.

**Pennsylvania Medical Assistance** I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

**Commercial** **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby authorize payment directly to Main Line HealthCare for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

**General** **RELEASE OF INFORMATION** – Main Line HealthCare may disclose any or all parts of my clinical records to my insurance company or companies, or, in the case of Workers Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Main Line HealthCare and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account.

**GUARANTEE OF ACCOUNT** – Main Line HealthCare

For and in consideration of services rendered by Main Line HealthCare to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Patient's Agent Representative and Guarantor Signature Date