**Insurance claim authorization signature form**

DO NOT COMPLETE THIS FORM UNLESS YOU HAVE BEEN ASKED TO DO SO

Patient Name:_____

Birth date:_____

Address:_____

Telephone:_____

Primary insured name:_____

Primary insured address:_____

Primary insured phone:_____

Insurance plan name:_____

Member ID:_____

Is patient covered by any other health benefit plan? Yes___ No___

I have reviewed a sample HCFA form (one may be found on holladaymd.com). ___ (initial)

[Note: these authorizations apply to any bills or claims submitted by HolladayMD or Dr. Holladay]
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED_____ DATE_____
(Patient)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED_____
(Primary insured)

I authorize Nathan Holladay to fill in an insurance claim form (HCFA) based on the above information and to sign box 12 (and box 13, if I am the primary insured) on my behalf, due to difficulty in providing a signed physical or electronic copy of this form to him. This authorization expires 30 days after the date of my signature.

SIGNED_____ DATE_____

Name:_____