ASSIGNMENT OF BENEFITS (AOB) / INSURANCE AUTHORIZATION FORM

☐ Geisinger Clinic: PrimeMed Medical Group
☐ Geisinger- Viewmont Imaging ☐ Geisinger- Viewmont Medical Labs
☐ Geisinger- Viewmont Physical Therapy ☐ Geisinger- Viewmont Sleep Disorder Center

Acct# Acct # Patient Name Pat Whole Name (First Name First) Date: Crt Date

☐ **MEDICARE**

Statement to Permit Payment of Medicare Benefits to Provider, Physician and Patient

I request payment of authorized Medicare benefits to me or on my behalf for any service furnished me by or in Geisinger, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for releated services. I understand I am responsible and will pay Geisinger for any health insurance deductibles, co-insurance or services not covered by the Medicare program as defined by the Social Security Act.

Date: 00/00/0000 **Time** **Signature:**
Date: 00/00/0000 **Time** **Other: Signature:**

☐ **MEDICAL ASSISTANCE** **RECIPIENT NO:**

"My signature certifies that I received a service or item on the date listed above. I understand that payment for services or items will be from Federal and State Funds, and that any false claims,statements,documents, or concealment of material may be prosecuted under applicable Federal and State Laws." I have read and agree with this statement. I understand I am responsible and will pay Geisinger any deductible, co-pays and co-insurance amounts or other non-covered service as defined by Medical Assistance

Date: 00/00/0000 Time : Signature:

☐ **NO FAULT.AUTO** ☐ **WORKER'S COM** P
INSURANCE CO EMPLOYER

Authorization to Release Medical Information- I authorize Geisinger to release any information requred to complete my compensation and or insurance claim to my employer/ insurance company pertaining to my visit. If my visit is the result of a Motor Vehicle Accident, I understand I am responsible and will pay Geisinger for services not covered by my No-Fault policy

Date: 00/00/0000 Time: Signature:

☐ **OTHER INSURANCES**

I authorize Geisinger to release any medical and other information needed to determine the benefits or benefits for related services provided. I understand that I am financially responsible for all charges not covered by my insurance or unpaid within a reasonable time.

Date 00/00/0000 Time: Signature:

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign to Geisinger and authorize that payment be made directly to Geisinger for all benefits otherwise payable to me under the terms of my insurance policies (including major medical policies) by reason of the services described in the statement rendered by Geisinger. Geisinger shall refund any payment in excess of its full regular charges to the person(s) entitled to receive the same benefits. I understand that I am financially responsible for all charges not covered by my insurance or unpaid within a reasonable time.

Date: 00/00/0000 Time Signature:

☐ **SELF PAY**

I am uninsured and understand that I am responsible for all charges related to services provided to me or to the patient noted above. I understand I am responsible to notify Geisinger if/when I obtain insurance coverage that may apply to this date of service, and that I fail to do so, I remain responsible for all charges.

Date: 00/00/0000 Time: Signature:

☐ **PATIENT REFUSED TO SIGN** **GEISINGER REPRESENTATIVE INITIALS**