Strobel & Associates PROSTHETICS

Benefits Information

Mr. Mrs. Miss
Patient Name _____ Date _____
Last Name First Name M.I.

Primary Insured Person _____

Insured's Employer _____

Insured's SS# _____ Insured's Date of Birth _____

Relationship to Insured: Self Spouse Child Other _____

Primary Insurance Company Name _____

Group ID# _____ Copay amount _____

Policy ID# _____

Insurance Address _____

Secondary Insurance Company Name (only if primary is out of network) _____

Group ID# _____ Copay amount _____

Policy ID# _____

Insurance Address _____

I authorize **Strobel & Associates Prosthetics** to release and furnish on a confidential and strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, managed care organizations, IPA's, Medicare or other government or third party payors, or any organizations contracting with any of the above entities to perform such functions. I also understand and agree that I am responsible for payment of services rendered which are deemed as a non-covered benefit or not medically necessary by my insurance company. I agree that a copy of this authorization shall be considered as effective and valid as the original.

Signature _____ Date _____