MR#: _____

SELMA MEDICAL ASSOCIATES, INC.
Insurance Authorization / Billing Update

Dear Patient,
We will submit a claim for services to your insurance carrier if we participate. In order to do so, please complete each blank on this form, front and back. Self-pay patients need to complete Sections 1 and 2 only. All other patients need to complete the entire form.

SECTION 1 – PATIENT INFORMATION

Patient's Name: _____

If a minor, Person Responsible for Account: _____

Full Address: _____ Home Phone: _____

_____ Work Phone: _____

Patient's Date of Birth: _____ Patient's SS#: _____ Cell Phone: _____

Patient's Race: _____ Patient's Ethnicity: _____

Patient's Language: _____ Martial Status: _____

Patient's Employer: _____

SECTION 2 – AUTHORIZATION FOR SELF-PAY PATIENTS
(To be completed by patients that do not have any insurance.)

I hereby understand that I am responsible for all payments to ***Selma Medical Associates, Inc.*** for treatments and all medical services rendered to myself or my dependents. I authorize photocopies of this form to be as valid as the original. I waive all claims as to proper venue for hearing of this matter and agree that the City of Winchester, Virginia shall be proper venue for hearing and claim hereunder.

Signature (Patient): _____ Date: _____

SECTION 3 – INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Insured's Name: _____

Insured's Identification Number (as it appears on the card): _____

Group Number (as it appears on the card): _____

Insured's Social Security Number: _____

Insured's Date of Birth: _____

Patient's Relationship to Insured: _____

Insured's Employer: _____

Effective Date of Policy: _____

Name of Insurance Company: _____

Claims Address of Insurance Company: _____

_____

Phone Number of Insurance Company: _____

(Over)

SECONDARY INSURANCE INFORMATION:

Insured's Name: _____

Insured's Identification Number (as it appears on the card): _____

Group Number (as it appears on the card): _____

Insured's Social Security Number: _____

Insured's Date of Birth: _____

Patient's Relationship to Insured: _____

Insured's Employer: _____

Effective Date of Policy: _____

Name of Insurance Company: _____

Claims Address of Insurance Company: _____

_____

Phone Number of Insurance Company: _____

SECTION 4 – AUTHORIZATION AND ASSIGNMENT OF MEDICARE BENEFITS

(Only Medicare Beneficiaries need to complete this section.)

Name of Beneficiary (Patient): _____

Medicare Number: _____

I request that payment and authorized Medicare benefits be made to either me or on behalf to ***Selma Medical Associates, Inc.*** for any services furnished to me by a physician in that group. I authorize any holder of medical information about me to release ***Center of Medicare/Medicaid Services (CMS)*** and its agents any information needed to determine these benefits payable for related services.

Signature of Beneficiary (Patient): _____ Date: _____

SECTION 5 – COMMERCIAL INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

(This needs to be completed if you have insurance.)

I hereby authorize ***Selma Medical Associates, Inc.*** to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or dependants. I understand that I am responsible for any amount not covered by insurance.

I authorize photocopies of this form to be as valid as the original.

I waive all claims as proper venue for the hearing of this matter and agree that the City of Winchester, Virginia shall be proper venue for hearing and claim hereunder.

Signature (Patient): _____ Date: _____

Revised: 03/14/2013