

IQBAL & KHAN SURGICAL ASSOCIATES, PA

INSURANCE

ONE TIME AUTHORIZATION

Name of Insurance Company
Insurance Claim #

I Request that payment of authorized medical/miscellaneous insurance benefits be made on my behalf to IQBAL & KHAN SURGICAL ASSOCIATES, PA for any services furnished of me by these physicians. I authorize any holder of medical information about me to release to the health care financing administration and/or its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient
(Or Representative)

Date

One time authorization must be obtained and retained in the physician's files. Once the physician has obtained the patient's one-time authorization, he may submit any later medicare/miscellaneous insurance claims, on either an assigned or non-assigned basis, without obtaining any additional signatures from the patient.

I request that payment of authorized Medigap Benefits be made on my behalf to IQBAL & KHAN SURGICAL ASSOCIATES, PA for any services furnished me by these physicians/suppliers. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for these related services.

Signature of Patient
(Or Representative)

Date

My signature below certifies that I have REVIEWED THE HIPPA GUIDELINES from the office of IQBAL & KHAN SURGICAL ASSOCIATES, PA.

Signature of Patient
(Or Representative)

Date