

**The Medical Care Group, LTD.
INSURANCE BILLING AUTHORIZATION**

Patient Name: _____

Date of Birth: ____/____/____ Social Security #: _____

I authorize the release of any medical information necessary to process my medical insurance claim. I hereby authorize payment directly to the provider of service.

Patient/Guardian Signature: _____ Date: _____

Complete 1 of the 2 sections below; choose the section that best applies to your insurance coverage.

*I certify that in addition to my **Primary** insurance coverage from: _____*

*I am also eligible to receive **Secondary** insurance coverage from: _____*

(Ins. address and phone #)

Subscriber: _____ Policy #: _____ Group #: _____

Type of Policy: _____ Individual (or) _____ Group

OR

I certify that I have no additional insurance coverage other than through: _____

*I also certify that should my insurance coverage change at anytime, either through addition, termination or change of a plan, I will notify **The Medical Care Group**.*

Patient Name

Date

Patient/Guardian Signature