CLAIMS AUTHORIZATION FOR MEDICARE, EMPIRE BLUE CROSS BLUE SHIELD OR OTHER HEALTH INSURANCE COMPANIES

BLUE SHIELD AND OTHER HEALTH INSURANCE COMPANY:

I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish any and all records, medical history, services rendered or treatment rendered to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to Empire Blue Cross and Blue Shield or other insurer.

I also authorize Empire Blue Cross and Blue Shield of Greater New York or other insurer to disclose to a hospital or health care service plan, self-insurer, any medical information obtained if any such disclosure is necessary to allow the processing of any claim.

If my coverage is under a group contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with Empire Blue Cross and Blue Shield of Greater New York or any other insurer including a reasonable time thereafter, until it's final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.

OTHER HEALTH INSURANCE ASSIGNMENT OF BENEFITS:

I authorize payment of Medical Benefits directly to ***Dr. Jonathan M. Vapnek***

_____

Patient/Spouse/Guardian Signature

_____ _____

Date Patient's Name (Print)

MEDICARE ASSIGNMENT OF BENEFITS:

I request that payment of authorized Medicare Benefits be made to this office for any service furnished by Dr. Jonathan M. Vapnek to me. I authorize any medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits for the related services.

I authorize payment of Medical Benefits directly to ***Dr. Jonathan M. Vapnek***

_____

Patient/Spouse/Guardian Signatue

_____ _____

Date Patient Name (Print)