PACIFIC EYE INSTITUTE

PAYMENT OF INSURANCE BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to PACIFIC EYE INSTITUE. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature acknowledges request that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing information to the insurer or agency shown.

I understand I am responsible for any deductibles, co-deductible, co-insurance and non-covered services.

Printed Name _____ Date _____

Signature _____