HAMPTON UNIVERSITY
PROTON THERAPY INSTITUTE

A Center for Focused Cancer Care.

Insurance Authorization Form

Medicare/Insurance Assignment
Financial Agreement – Information Release/Authorization to Inquire

Patient's Name	Date of Birth	Verification of identity (Driver's License, ID Card, Passport, etc.)	
Patient's Address		Telephone #	Medical Record #

**Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority
Representative's Address	Verification of Identity	Verification of Authority

Insurance Company/Policy Information

Date:

Insurance Company/Policy #1:

Insurance Company_____

Policy Number _____

Group Number _____

Secondary Insurance Company/Policy #2:

Insurance Company_____

Policy Number _____

Group Number _____

I hereby authorize and assign direct payment to HUPTI for benefits arising out of any insurance policy, for Medicare benefits, or for payment from any party liable to me.

I understand and agree I am financially and legally responsible for charges not covered by this agreement. I further agree to pay all costs of collection for any such unpaid balance, including reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in place of the original.

I understand that HUPTI will accept assignment on assignable insurance coverage as a courtesy to its residents and that acceptance of assignment does not relieve the patient's liability for payment of services. Should insurance not pay in whole or in part for any services rendered, the patient is responsible for payment to HUPTI.

For Medicare benefits, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to HUPTI.

I further authorize HUPTI to make inquiry of the Department of Public Welfare and other agencies or individuals as to my medical and financial status and give consent to such agencies and indivuals to make available pertinent information relative to my circumstances. (If applicable)

I have read and understand the information in this authorization form.	
Signature of Patient or Legal Representative	Date

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