## HEALTHSOURCE SAGINAW SAGINAW, MICHIGAN

## STATEMENT TO PERMIT PAYMENT OF HOSPITAL AND MEDICAL INSURANCE BENEFITS TO HOSPITAL

(NAME OF PATIENT/RESID (Insurance	ENT) DATE carrier):
I certify that the information given by me in applying for payment under TITLE XVIII (Medicare) and	
TITLE VIV (Mediecid) and/or	
TITLE XIX (Medicaid) and/or	ation needed to act on this request as specified in Medicare
rules & regulations 191.3A	ation needed to act on this request as specified in Medicare
	ealth insurance claim number
2. Coinsurance a	
3. Dates of entitl	lement to Medicare
4. Copies of Med	dicare claim forms
	ort of eligibility
6. Explanation o	f Medicare benefits (EOMB)
understand I am responsible for any health is covered by my insurance.	spital is authorized to bill in connection with its services. I nsurance deductibles and any remaining charges not
I request that this authorization apply to the	
I understand that this may be revoked at any reliance on this consent prior to revocation. Purpose for information being released:	x time except to the extent that action has been taken in  XXX Processing of claims
	Other
If you do not want information about please check this line.	t this Medicare claim released to your insurance company,
(WITNESS)	(PATIENT OR REPRESENTATIVE SIGNATURE)
INSURANCE COMPANY	
ADDRESS	
	SUBSCRIBER'S SS #
SUBSCRIBER'S EMPLOYER	POLICY/GROUP #