

MEDICAL INSURANCE INFORMATION FORM



***Please present your insurance card and a picture ID to the receptionist.
Prior authorization may be required before service is rendered.***

MEDICARE RECIPIENTS ONLY

Medicare # _____ - _____ - _____

(Please Circle)

- | | | |
|---|---------------------|---|
| 1. Is Medicare the primary insurance? | YES | NO |
| 2. Is the patient a VETERAN? | YES | NO |
| a. Did the VA refer the patient here for treatment? | YES | NO |
| b. Does the patient have a VA "FEE BASIS ID CARD?" | YES | NO |
| 3. Do patient have a "FEDERAL BLACK LUNG CARD?" | YES | NO |
| 4. Is the medical condition due to an accident of any kind? | YES | NO |
| If yes, please circle if it was: | work related | auto injured at home other |
| 5. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? | YES | NO |

PAYMENT POLICY AND AUTHORIZATION

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician and is not a substitute for payment. The policy of this office is that payment is due at the time of the office visit. It is expected that fees for office visits and minor procedures be paid at the time services rendered. Payment may be made by cash, check, or credit card. Our receptionist will provide an itemized statement of services for use in filing a claim with the insurance company.

Our office participates in various insurance programs which may require the patient to pay only co-payments, deductibles, or co-insurance amounts. Please verify with the receptionist whether you are covered by any of these programs.

I hereby authorize Nebraska Cancer Specialists, the physicians of Oncology Hematology West, P.C. to furnish my insurance company(s) or a designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign all money to which I am entitled for medical and/or surgical expense relative to the service rendered by undersigned physician, but not to exceed my indebtedness, to said physician and/or surgeon. I hereby assign all money to which I am entitled under Medigap to the physician who rendered services. This assignment applies to all dates of service until revoked. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctors for charges not covered by this assignment.

Insured or Guardian Signature

Patient Signature

Date