LAWRENCE S. LEIBOWITZ, D.P.M.
31 ROUTE 206, SUITE 1
AUGUSTA, NEW JERSEY 07822
PHONE (973) 383-5421/FAX (973) 579-0015

PATIENT'S INSURANCE AUTHORIZATION

PATIENT'S NAME _____ DATE OF BIRTH _____

PRIMARY INSURANCE COMPANY _____

PRIMARY INSURANCE ID NUMBER _____

SECONDARY INSURANCE COMPANY _____

SECONDARY INSURANCE ID NUMBER _____

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO LAWRENCE S. LEIBOWITZ, D.P.M. FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN/SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO HEALTH CARE FINANCING ADMINISTRATION AND/OR ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE UNDER RELATED SERVICES.

I UNDERSTAND THAT MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIMS. 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 AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE, AND NON-COVERED SERVICES. CO-INSURANCE AND THE DEDUCTIBLE ARE BASED UPON CHARGE DETERMINATION OF THE CARRIER.

_____ _____
PATIENT'S SIGNATURE DATE

PLEASE SIGN AND RETURN THIS FORM TO OUR OFFICE FOR MEDICAL BOOKKEEPING.
-INCLUDE A COPY OF THE PATIENT'S PRIMARY AND SECONDARY INSURANCE CARDS – BOTH FRONT AND BACK OF EACH CARD
- MAKE CERTAIN THE FORM LISTS THE CORRECT SPELLING OF FIRST AND LAST NAMES AND DATE OF BIRTH
- IF ANY QUESTIONS, PLEASE CALL 973-263-1776

THANK YOU.