



Assignment of Insurance Benefits

I hereby authorize payment directly to Eau Claire Medical Clinic, for services provided at Eau Claire Medical Clinic that are covered by my medical insurance. It is also understood that any medical and/or other information necessary to process this claim will be released upon request from the insurance carrier.

Name: _____

Signature: _____

Date: _____

Patient Signature on File for Medicare Claims

Printed Name: _____

Medicare Number: _____ - _____ - _____

I request that payment for authorized Medicare benefits be made either to me or on my behalf to Eau Claire Medical Clinic, for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

This authorization is in effect until I choose to revoke it. *

Signed: _____

Date: _____

*If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.