EAR, NOSE & THROAT ASSOCIATES
WILSON T. BARHAM, M.D.
LEE A. MILLER, M.D.

INSURANCE AUTHORIZATION / FINANCIAL POLICY

I hereby authorize ENT Associates of Northeast Louisiana, LLC to furnish information to my insurance carrier concerning my medical history, illness(es), treatments, etc., or any information needed to process my insurance claim. I authorize and request payment of medical benefits directly to the physician for any service not paid in full by myself. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

All deductibles, co-payments or full payments (for non-contracted or uninsured patients) are required at the time of service. If for any reason my insurance company denies payment for any services considered to be medically necessary by my physician but are "non-covered procedures" or "elective procedures" according to the terms of my insurance coverage, then I agree to be responsible for payment of these charges in full. Each individual insurance company determines their own "reasonable and customary" allowances for all services. If my insurance company determines that my charges are above their "reasonable and customary" allowances, then I agree to be responsible for payment of these charges in full.

I have read and understand this policy:

SIGNATURE: _____ DATE: _____

MEDICARE AUTHORIZATION

Patient's Name: _____

Patient's Medicare Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to ENT Associates of Northeast Louisiana, LLC for any services furnished to me by the physicians. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information needed to determine those benefits of the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in the Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insured or agency shown. In Medicare assigned cases, the physician or supplies agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: _____ DATE:_____

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