Reed I Ward D O
Family Medicine Physician

REED I. WARD, D.O.
3425 Potomac Way
Idaho Falls, ID 83404
Office: (208) 528-8170

Authorization to Submit Insurance

IF YOU HAVE THE FOLLOWING

Commercial Insurance: We are happy to, as a courtesy, to submit primary and secondary insurance carriers for your service up to the timely deadline, but cannot accept responsibility negotiating payment with them on your behalf. It is the patient's responsibility to make sure claims are processed timely.

Medicaid: Please present your current medical card at the time of service along with any Healthy Connection referrals. It is the patient's responsibility to provide referrals or patient will be responsible for payment.

No Insurance: Services are to be paid at the time of service in full unless specific arrangements are made.

Authorization to Release Information

We will submit a claim to your insurance company for services that are provided. In order for us to do this, we need your authorization to release medical information to your insurance company.

Medicare/Medicare Advantage/Medicaid Only: I request that payment of authorized carrier benefits be made on my behalf to REED I. WARD, D.O., P.A, for any services furnished to me by physician. 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 or the benefits payable for related services.

Patient Signature:_____ **Date:**_____

Medigap (Patients who carry a secondary insurance to Medicare Plans): I Request payment of authorized Medigap benefits be made on my behalf to REED I. WARD, D.O., P.A., for any services furnished to me by physician. I authorize any holder of medical information about me to release any information needed to determine these benefits.

Patient Signature:_____ **Date:**_____

Private Pay/Commercial (Non-Medicare): I authorize the release of any medical information necessary to process the claim and request payments of benefits to REED I. WARD, D.O., P.A.. I understand that regardless of insurance coverage I am responsible for payment for my services.

Patient Signature:_____ **Date:**_____

I understand that my medical insurance company may not pay for all of the services provided because they may not be a covered benefit. If this is the case, I understand I will be responsible for payment of this service.

By signing below I acknowledge that I wish to have services performed and agree to be responsible for payment of the service if the insurance company does not cover the service.

Patient Signature:_____ **Date:**_____