Main Line HealthCare
Physician Network

Z PSF

Patient Name_____ Date of Birth _____

PATIENT SIGNATURE ON FILE FORM

Medigap (Medicare Secondary Insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Main Line HealthCare for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap Coverage) any information needed to determine these benefits payable for related services.

PENNSYLVANIA MEDICAL ASSISTANCE

I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

COMMERCIAL

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Main Line HealthCare for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

GENERAL

RELEASE OF INFORMATION – Main Line HealthCare may disclose any or all parts of my clinical records to my insurance company or companies, or, in the case of Workers Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Main Line HealthCare and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account.

GUARANTEE OF ACCOUNT – Main Line HealthCare

For and in consideration of services rendered by Main Line HealthCare to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____ _____

Patient's Signature Date

_____ _____

Patient's Agent Representative and Guarantor Signature Date