Healthy Horizons Clinic

Insurance Authorization and Assignment

Name of Policy Holder: _____

I request that the payment of authorized Medicare/Other Insurance Company benefits be made either to me, or on my behalf, to Moazam P.A. DBA Healthy Horizons Clinic for any services furnished to me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section1129B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: _____ Date: _____