



Miller Care Group  
3850 Shore Drive, Suite 315  
Indianapolis, IN 46254

(P)317-429-0061  
(F)317-222-1953

## **INSURANCE INFORMATION**

### **INSURANCE ASSIGNMENT AND RELEASE**

I certify that I have insurance coverage with: \_\_\_\_\_

**Name of Insurance Company(ies)**

and assign directly to Dr. \_\_\_\_\_

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose or obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co. \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

### **MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to: \_\_\_\_\_

**Name of Doctor or Clinic**

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

\_\_\_\_\_  
**E-Signature of Beneficiary, Guardian or Personal Representative**

\_\_\_\_\_  
**Please Print of name of Beneficiary, Guardian or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Beneficiary**