BOSTON FOUNDATION *for* SIGHT

ASSIGNMENT OF BENEFITS

In accordance with the Health Insurance Portability Act of 1996 (HIPAA), I authorize the release of my Protected Health Information in order for filing claims.

MEDICARE: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Boston Foundation for Sight, for services furnished to me by Boston Foundation for Sight. 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 for 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 item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing of the information to the insurer or agency shown.

Boston Foundation for Sight accepts the charge determination of the Medicare carrier, Blue Cross/Blue Shield of Massachusetts, as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP: If a Medicare policy or health insurance is indicated in item 9 or the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or my behalf to Boston Foundation for Sight.

OTHER INSURANCE: I hereby authorize payment of my medical insurance benefits to Boston Foundation for Sight. I understand that I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Boston Foundation for Sight. I authorize Boston Foundation for Sight to release any information required to process and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Print Name **Date**

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Signature