INSURANCE/MEDICARE and/or MEDI-CAL AUTHORIZATION STATEMENT

FOR CLAIMS SUBMISSION

Client Name _____
(Please print name)

I request that payment of authorized Insurance, Medicare and/or Medi-Cal benefits be made on my behalf to **Jewish Family Service of The Desert** (**JFS**) for any services furnished to me by the physician or supplier. 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 payable to related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In Medicare and/or Medi-Cal assigned cases, the physician or supplier agrees to accept the charge determination of the carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare and/or Medi-Cal carrier.

Client Signature _____ **Date** _____
(Parent/Guardian's signature if minor)

Last Revision 3/30/2016