Assignment of Medicare Benefits

Patient Name: ______________________________

Medicare Beneficiary #: ______________________________

For Medicare Patients:

I request that payment of authorized Medicare benefits be made on my behalf to **Pennsylvania Eye Associates/Pennsylvania Eye Surgery Center** for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Medigap or other Secondary Insurance:

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Pennsylvania Eye Associates/Pennsylvania Eye Surgery Center, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer, or any information needed to determine these benefits payable for related services. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Patient's or Authorized Person's Signature:

Signature X ______________________________ **Date** ____________

Pennsylvania Eye Associates • 4100 Linglestown Road Harrisburg, PA 17112
717-657-2020 • 800-382-2020 • www.memorialeye.com

Memorial Eye Institute Financial Policy

Our physicians and staff appreciate your choosing Memorial Eye Institute. Please take a moment to review the following Statement of Financial Policy.

All charges for services are due on the day we provide the service. We accept the following as methods of payment: Credit/Debit Cards (Visa, MasterCard, & Discover), Personal Checks, Cash, & Health Insurance.

We participate with, and accept assignment for most major insurance carriers. We will submit a claim for medical services to your insurance carrier. In order to do this, you must provide us with **VALID INSURANCE CARRIER & POLICY ID INFORMATION**, as well as your **CORRECT BILLING ADDRESS**. You are responsible for any co-pay, deductible, and co-insurance amounts as required by your policy coverage. Ultimately, you are responsible for all charges you have incurred. Please be aware that some services we provide may be considered “non-covered” by your insurance carrier, and are also your responsibility.

If the patient is a **MINOR**, the parent or guardian accompanying the child on the day of the visit is responsible for payment. This applies in all cases, including divorce cases. If both parents have insurance, it is your responsibility to inform us which insurance is primary. Please verify this with your insurance carrier prior to your visit. Any child, 18 or over, is an adult and is responsible for his/her bill, regardless of residence or student status.

Finance Plans: Memorial Eye Institute offers convenient financing through Chace Health Advance, a vision services finance plan. Our staff will be happy to provide you with the necessary information.

Billing Policies to be Aware of Prior to your Visit:

1. If your insurance policy requires a **REFERRAL** from your family doctor, please have it with you when you arrive. We may choose to reschedule your appointment if you did not obtain the required referral. **COPAYS** that are required by your insurance carrier will be collected when you arrive. If we must bill you for a copay, a $10.00 processing fee will be added.
2. Fees for **NON-COVERED SERVICES** are collected when you check out after your visit. These include charges for services that your insurance will not pay, such as office visits (in the case of Traditional Blue Plans), and refractions, elective and cosmetic procedures (services not covered by Medicare). In addition, you may be required to pay deductible or co-insurance amounts at the time of your visit.
3. If we **DO NOT PARTICIPATE** with your insurance carrier, or if your insurance routinely pays you directly, you are responsible for payment of all charges on the day of your visit.
4. If we are participating with your insurance carriers, we will submit claims to your **PRIMARY** and **SECONDARY** health insurances only. If your **SECONDARY** insurance does not cross over from Medicare we will submit it **one time**. In the event that payment is not received by your secondary insurance company within sixty (60) days after receiving payment from your **PRIMARY**, outstanding balances to Pennsylvania Eye Associates/Pennsylvania Eye Surgery Center will become your responsibility. It is your responsibility to file claims with any additional insurances you may have.

The Billing Process:

1. We will submit claims to participating insurance carriers within 5 days of the date of service.
2. If appropriate payment is not received within 60 days, outstanding balances become your responsibility. A statement will be issued to you. Payment is due within 10 days of receipt of this statement.

*** Please note:** If a personal check is returned from your bank, a $25.00 returned check fee will be charged.

Patient’s or Authorized Person’s Signature:

I the undersigned give my authorization to treat and assign directly to Pennsylvania Eye Associates/Pennsylvania Eye Surgery Center, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service, and that I agree to the financial policy above.

I acknowledge receipt of the Practice’s Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services and conducting healthcare operations.

Signature X ______________________________ **Date** ______________

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