ASSIGNMENT OF INSURANCE BENEFITS

Patient/Resident Name_____

Medicare Number_____

I hereby authorize payment directly to The House of the Good Shepherd of any medical insurance benefits under Medicare, Medicaid or 3rd party insurance for services rendered to me.

I hereby authorize the Facility to file insurance claims on my behalf so that the Facility may be paid for my charges. I understand that if the Facility does not receive payment from the insurer(s), I am personally responsible for the timely payment of the Facility's charges.

I authorize The House of the Good Shepherd to release any information that is needed to process any claims to Medicare, Medicaid or 3rd Party insurance carriers. I agree to allow a photocopy of my signature to be used for insurance claims purposes. This authorization will remain in effect until revoked by me in writing.

Patient/Resident _____

Resident Representative_____

Date_____

Rev. 07-2017 db