Suburban Rheumatology/Suburban Medical Group

8207 Main Street, Suite 7 & 8
Williamsville, NY 14221
(716) 626-4200 (phone) & (716) 626-4201 (fax)

STATEMENTS OF AUTHORIZATION

Statement to Authorize Payment of Insurance Benefits

I authorize the release of my medical information necessary to process any submitted claim by the office of Medical Staff at Suburban Medical Group. I also authorize payment of medical benefits to the above named physician for services provided to me.

Statement to Authorize Payment of Medicare Benefits

I certify that the information given by me in applying for payment under Title XVII of the Social Act is correct. I authorize any holder of medical information about me released to the Social Security Administration, or its carriers, and information required to process my Medicare Claims. I request that payment under the medical insurance program be made either to me or for services provided to me.

Required Referral

I agree to obtain the proper referral based on my insurance carrier regulations if applicable. I understand that if I do not obtain the proper referral form, I will be responsible for all charges and I will be billed directly.

Statement of Medical Release

I authorize the release of my medical information to other physicians who I am under the care of (PCP's, specialist, etc.). I understand that there is a charge for records requested in accordance with the NY State law of .75 per page.

By signing below, I acknowledge that I have read and understand the above and consent to all contents and intentions.

Signature:_____ **Date:**_____