Eden Medical Plaza
20126 Stanton Ave. #205
Castro Valley, CA 94546

Plaza Real
39210 State St. #100
Fremont, CA 94538

Phone 510.537.4211

INSURANCE BILLING AUTHORIZATION FORM

This form authorizes the The Hearing Center of Castro Valley to use or disclose your patient health information to bill Medicare, Medi-Cal, CCS, or your private insurance company for hearing evaluation and/or hearing aid purchase.

"I request that payment of authorized Medicare, Medi-Cal, CCS and/or other insurance benefits be made on my behalf to The Hearing Center of Castro Valley for services provided me by The Hearing Center of Castro Valley, its agents, and employees. I authorize any holder of medical information about me to release to The Hearing Center of Castro Valley, Medicare, Medi-Cal, CCS, and/or any other insurance company including its agents and employees, any information or documentation needed to determine these benefits or the benefits payable for related services."

"I understand my signature requests that payment be made and authorizes release of medical information necessary to secure payment for the claim. If I have supplemental health insurance coverage, my signature authorizes releasing the medical information to the supplemental insurance company, its agents, and employees. This signature authorization shall remain in effect until revoked by me in writing. I understand that The Hearing Center of Castro Valley is HIPPA compliant and I have the right to request a copy of The Hearing Center of Castro Valley's Privacy Notice and to review it before signing this authorization form. A photocopy of this authorization is to be considered as valid as an original."

BILLING YOUR INSURANCE DOES NOT GUARANTEE PAYMENT.
THE AMOUNT PAID BY INSURANCE CANNOT BE GUARANTEED.
YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR BALANCE.

Patient's Name (PRINT): _____

Patient's Signature: _____

Date: _____

Primary Insurance: _____
Subscriber's Name (if other than patient): _____
Subscriber's Date of Birth:_____/_____/_____

Secondary Insurance: _____
Subscriber's Name (if other than patient): _____
Subscriber's Date of Birth:_____/_____/_____

Insurance Provider:

_____

ID Number _____

Group Number _____

Secondary Insurance: _____

ID Number _____

PPO/HMO [circle one]

Referred by: _____

Required for Medicare /HMO

Provider phone number [on back of card] _____
If you can send a copy of front and back of your insurance card