CLINTON SERVICE UNIT
ASSIGNMENT OF BENEFITS (A.O.B.) AND AUTHORIZATION TO BILL

I authorize the Indian Health Service (IHS) to disclose all or any part of my record to any person or corporation which is may be liable under a contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charge, including but not limited to hospital or medical service companies, insurance companies, workman's compensation carriers, Centers for Medicare and Medicaid Services, welfare funds, Medicare benefits payable under Title XVII of the Social Security Act, or the patient's employer.

I understand that the information authorized for release may include information which may be considered a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I hereby assign and convey directly to Indian Health Services, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Indian Health Services, regardless of its managed care network participation status. I request and authorize payment of Medicare and such benefits be made on my behalf to Indian Health Services for any services furnished to me. Unless revoked, this authorization to furnish information and assignment of benefits is valid for all administrative and judicial reviews under the health care reform legislation, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name: _____ Signature: _____

Policy Number: _____ Date: _____

Health Record Number: _____ Policy Holder DOB: _____

Name of Insurance: _____

Legal name of policy holder (if different than patient): _____

Policy Holder Name of Employer: _____

Next, please check below which benefits the above policy provides. Otherwise, please complete a separate **A.O.B. and Authorization to Bill** form for each policy.

☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy ☐ Behavioral Health

Please list the name(s) of dependents, including spouse, covered by policy and dates of birth:

1. _____ DOB: _____

2. _____ DOB: _____

3. _____ DOB: _____

4. _____ DOB: _____

5. _____ DOB: _____