BORINQUEN MEDICAL CENTERS

MEDICAID & MEDICARE
PAYMENT AUTHORIZATION FOR HOSPITAL AND PHYSICIAN SERVICES

Patient Name _____ MR#_____

I certify that the information given by me in applying for payment, under the Title XVIII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administrator or its intermediaries or carriers, any information needed for this or a related Medicaid or Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare and/or Medicaid for payment. This authorization shall be effective for a period of 1 year. I also certify that if I assign my Medicare and/or Medicaid to another HMO it is with the understanding that BMC will not be responsible for my health care.

Signature _____ Date _____
(Patient or authorized representative)

MEDICAID & MEDICARE
AUTORIZACION DE PAGOS POR SERVICIOS HOSPITALARIOS Y MEDICOS

Nombre del Paciente _____ MR#_____

Yo certifico que la información que ofrecí en mi solicitud para realizar mis pagos bajo el Titulo XVIII y/o XIX del Acta de Seguro Social es correcta. Autorizo a cualquiera que tenga información médica o de otro tipo acerca de mí, que ofrezca a la Administración del Seguro Social, sus intermediarios de pago relacionada con el Medicare o Medicaid, yo solicito que el pago de los beneficios que sean autorizados sean hechos según esta petición yo transfiero los beneficios pagaderos por servicios médicos al médico o organización que preste los servicios y autorizo a tal médico o organización a someter una reclamación al Medicare o Medicaid para pagar. Esta autorización tendrá vigencia de un ano. También certifico que si yo asigno mi Medicare o Medicaid a otro HMO, entiendo que BMC no será responsable del cuidado de mi salud.

Firma_____ Fecha_____
(Paciente o representante autorizada)

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Signature _____ Date _____
(Patient or authorized representative)

MEDICAID & MEDICARE
OTORIZATION PÈMAN LOPITAL AK DOKTÈ

Non Pasyian _____ MR#_____

Mwen sètifié ké infomasion m'bay nan aplikasion pou pèman amba sou tit XVIII é/ou XIX nan kontra social sékirité vré. Mwen otorizé tout moun ki guin aksè a infomasion médikal ou lot ki konsèné'm yo ka baye yo a réksponsab social sékirité ou lot intèmédiè pou ka sa é pou réklamasion Ki guin rapo ak Medikèd ou bien Medikè. Mwen mandé ké pèman bénéfis yo fèt sou non mwen. Mwen bay dwa pou péyé bénéfis pou sèvis médikal a doktè ou oganizasion ki founi sèvis médikal, et mwen otorizé doktè ou oganizasion sa pou mandé toushé nan Médikè é/ou Médikéd nan non mwen. Otorizasyon sa a ap efikas pou yon peryòd de 1 ane. Mwen sètifye tou si mwen asiyen Medicare ak / oswa Medicaid mwen nan yon lòt HMO mwen konprann ke BMC pap responsab pou swen sante mwen..

Signati _____ Dat _____
(Pasyan ou réprézantan Otorizé)