Delaware Valley Nephrology and Hypertension Associates, PC

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I have completed the attached form to the best of my ability. I authorize Delaware Valley Nephrology to bill the Insurance indicated as my primary insurance carrier.

I hereby authorize payment directly to Delaware Valley Nephrology of the group insurance benefits otherwise payable to me. I authorize release of all information relating to this claim. I understand that I am responsible for all costs of treatment.

_____ _____
(Signature of Patient/Representative) (Date)

MEDICARE PATIENTS ONLY:

PATIENT AUTHORIZATION FORM

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare or other insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that I must inform my physician if I know that a party other than Medicare is responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits apply.

_____
(Signature of Patient/Representative)

_____
(Date)

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