Richard F. Smith, D.O.
15 The Parkway
Katonah, NY 10536
(914) 232-5955 / Fax: (914) 206-4728

We must have your authorization in order to respond to any correspondence from your insurance carrier.
Please sign this form so that we may help you obtain reimbursement.

Patient's Name: _____
Please print clearly

Insured's Name: _____
Please print clearly

Relationship to insured: _____
Please print clearly

I authorize the release of any medical or other information necessary to process insurance claims.

_____ _____
Signature Date

For Medicare Patients ONLY: Medicare Number: _____

I request payment of government benefits either to myself or the party accepting assignment.

_____ _____
Signature Date

Secondary Insurance: _____ Policy/Group#: _____

Address: _____ Phone: _____

_____

Insured's Address: _____ Phone: _____

_____ Date of birth: _____

I authorize payment of medical benefits to Dr. Smith for medical services provided:

_____ _____
Signature Date

Revised 2/4/2003