

Request for Billing for Payment

Many patients have health insurance and/or vision care insurance that will cover the cost of at least some of the medical services and materials (glasses, contact lenses) recommended or prescribed during your visit to our office.

At your request, our staff, on your behalf, will submit your medical services and materials bill to the insurance company you believe should be responsible for paying the bill for services/materials you received today.

If you complete and sign this form, our office will bill your insurance company for the insurance-allowable charges for medical services/materials received today.

Please circle the insurance company you want us to bill for today's visit.

Vision Service Plan (VSP)/ or other Vision Insurance

Medicare (not HMO**)

Other Insurance (not HMO**)

Insurer Name: _____

****HMO – We cannot bill for you**

PLEASE NOTE: You need to pay our office for all insurance-allowable co-pays and fees for services incurred that are not paid for by the insurance company you have checked off. You may also need to pay a \$45 charge for a refraction(exam for glasses) as a Medicare non-covered service when you receive a comprehensive evaluation of your eyes.

I understand that if my bill claim is rejected by the insurance company I selected, I will be personally responsible to pay for all insurance-allowable charges for services/materials incurred today in Northridge Ophthalmology. It will then become my sole responsibility to obtain reimbursement from my insurance company.

By checking and signing this form, I acknowledge that I understand and accept the conditions for having Northridge Ophthalmology bill my insurance company on my behalf.

Signature _____

Date _____

Print your name _____