Health & Mental Health Services

Los Angeles LGBT Center

AUTHORIZATION AND ASSIGNMENT

MEDICARE LIFETIME ASSIGNMENT AUTHORIZATION *(completed by Medicare eligible patients)*

Beneficiary Name _____ Medicare Card Number _____

I request that payment of authorized Medicare benefits be made to the Los Angeles LGBT Center on my behalf for any services furnished me. I authorize the release of my medical information to the Centers for Medicare and Medicaid Services and its agents as needed to determine benefits or the benefits payable for related services.

Beneficiary Signature _____ Date _____

MEDIGAP AUTHORIZATION (*completed by Medicare eligible patients with Medigap coverage*)

Beneficiary Name _____ Medigap Number _____

I request the payment of authorized Medicare benefits be made to the Los Angeles LGBT Center on my behalf for any services furnished me. I authorize the release of my medical information to the Medigap insurer: _____ and its agents as needed to determine these benefits or the benefits payable for related services.

Subscriber Signature _____ Date _____

AUTHORIZATION AND ASSIGNMENT *(completed by clients with Medi-Cal or third-party insurance)*

I authorize the Los Angeles LGBT Center to provide care and treatment and to release medical information that may be requested by insurance companies to whom I have submitted a claim, and hereby request _____ Insurance Company to pay the Los Angeles LGBT Center all benefits accruing to me under my Surgical, Hospitalization, and Medical Plan. I understand I am financially responsible to the Los Angeles LGBT Center for all charges not covered by this assignment.

Subscriber Signature _____ Date _____

TRANSGENDER HEALTH PROGRAM *(completed by transgender clients authorizing third-party billing)*

For third-party billing purposes, legally it is necessary for the Los Angeles LGBT Center to code the electronic medical record gender marker as it appears with your insurance carrier. We respect and affirm all our clients' gender identities; however, because of these billing restrictions, you may sometimes find your records reflect the incorrect gender. Thank you for your understanding.

CASH BASIS *(completed by all registered clients at least once annually)*

I have insurance that I choose not to use or have insurance that is unbillable. I understand I am financially responsible to the Los Angeles LGBT Center for all charges for services rendered.

Patient Signature_____ Date_____

NOTE: THE AUTHORIZATION CONTAINED IN THIS BOX EXPIRES 12 MONTHS FROM THE DATE OF SIGNATURE