NEBRASKA CANCER SPECIALISTS

the Physicians of Oncology Hematology West

Name: _____ **Date of Birth:** _____

Medical Insurance Information Form

Please present your insurance card and a picture ID to the receptionist. Prior authorization may be required before service is rendered.

Assignment of Benefits

I hereby authorize Nebraska Cancer Specialists, the Physicians of Oncology Hematology West, P. C. to furnish my insurance company(s) or designated attorney, all information which they may require in order to issue payment. I herby assign all payment(s) for services rendered by NCS to be issued directly to Nebraska Cancer Specialists. This assignment applies to all dates of service until revoked.

I have requested medical services from Nebraska Cancer Specialists and understand by making this request I become fully responsible for any and all charges incurred in the course of the treatment.

_____ _____

Patient/Responsibility Party Signature Date

_____ _____

Name of person who carries primary insurance Date of Birth Relationship to Patient

_____ _____

Witness Date

Medicare Recipients Only:

1. Is Medicare your primary insurance? **Yes** _____ **No** _____
2. Are you receiving 'Black Lung' benefits? **Yes** _____ **No** _____
3. Are the services to be paid by a government research program? **Yes** _____ **No** _____
4. Has the Department of Veterans Affairs authorized and agreed to pay for your care at this facility? **Yes** _____ **No** _____
5. Was this medical condition due to an accident? **Yes** _____ **No** _____
   If **yes**, please explain if it was: work related, auto, injured at home, or other:

   _____
6. Are you or your spouse covered under an employer's health plan through your/their employment or that of a family member? **Yes** _____ **No** _____