

# Surgical Care Specialists

A Full Service Surgical Practice

Abington Hospital Office Building  
1245 Highland Avenue, Suite 600  
Abington, Pennsylvania 19001  
215-887-3990 Fax: 215-887-1140

DATE: \_\_\_\_\_

PATIENT INFORMATION			
PATIENT'S NAME:		AGE:	DATE OF BIRTH: SEX: <input type="checkbox"/> M <input type="checkbox"/> F
PATIENT'S ADDRESS: STREET INFO:		CITY:	STATE: ZIP:
HOME PHONE #:	WORK PHONE #:	S.S. #:	MARITAL STATUS: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
FAMILY PHYSICIAN:		REFERRING PHYSICIAN:	

EMERGENCY CONTACT / PARENT OR GUARDIAN OF PATIENT			
NAME:			
ADDRESS: STREET INFO:		CITY:	STATE: ZIP:
TELEPHONE:		RELATIONSHIP TO PATIENT:	

IS PRESENT CONDITION RELATED TO:  ACCIDENT  AUTO  WORKER'S COMP.

INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY NAME:		AGE:	
GROUP NUMBER:	ID NUMBER:	EFFECTIVE DATES:	
INSURANCE COMPANY ADDRESS: STREET INFO:		CITY:	STATE: ZIP:
NAME OF SUBSCRIBER:	REFERRING PHYSICIAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> _____		
INSURANCE COMPANY PHONE:	SUBSCRIBER BIRTHDATE:	SUBSCRIBER SEX: <input type="checkbox"/> M <input type="checkbox"/> F	
SECONDARY INSURANCE COMPANY NAME:			
GROUP NUMBER:	ID NUMBER:	EFFECTIVE DATES:	
INSURANCE COMPANY ADDRESS: STREET INFO:		CITY:	STATE: ZIP:
NAME OF SUBSCRIBER:	REFERRING PHYSICIAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> _____		
INSURANCE COMPANY PHONE:	SUBSCRIBER BIRTHDATE:	SUBSCRIBER SEX: <input type="checkbox"/> M <input type="checkbox"/> F	

## AUTHORIZATION FOR RELEASE OF INFORMATION AND BENEFITS

I authorize any holder of medical information about me to release to Medicare, my insurance carriers or companies any information for this of a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payments of medical insurance benefits to be made payable to Surgical Care Specialists, Inc., 1245 Highland Avenue, Abington, PA 19001.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## WAIVER OF LIABILITY

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for:

(Specify the particular test(s)) \_\_\_\_\_  
For the following reason(s) \_\_\_\_\_

(Give reason(s) for possible denial)

I have been notified by my provider that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reason(s) stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.