Ottawa Eyecare LLC

1518 N. Perry Street
Ottawa Oh 45875
419-523-5670

Insurance Authorization Form
Signature on File / Assignment of Benefits

_____	_____
Patient/Beneficiary Name (Print)	Insurance Subscriber/Members Name (Print) (if not the Patient/Beneficiary)

---

1. I request that payment of authorized insurance benefits be made on my behalf to **Ottawa Eyecare LLC** for services furnished me by *Diane S. Dible, O.D. and Shane M. Maag, O.D.* I authorize any holder of medical information about me to be released and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown Ottawa Eyecare LLC, accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the insurance company.
2. I understand that I am responsible for all non-covered items, co-pays or deductibles not covered by this insurance or other insurance.

_____	_____
Patient/Beneficiary Signature or Authorized Party	Date

(Note: Scanned photo ID & insurance card(s) will be kept on file.)