HOUSTON surgical specialists

Robert G. Marvin, M.D.
6330 West Loop South Ste. 610
Bellaire, Texas 77401
Phone: 713-993-7124 Fax: 713-963-0476

HOUSTON SURGICAL SPECIALIST
INSURANCE PAYMENT FORM

Date: _____

Policy Holder: _____**D.O.B.** _____

Employer: _____ **Phone#** _____

ID#: _____**Group#** _____

SS#: _____

I hereby instruct and direct _____

Insurance Company to pay by check made out and mailed to:

Houston Surgical Specialist
3429 West Holcombe
Houston, TX 77025

If my current policy prohibits direct payment to doctor, I also instruct you to make the check to me and mail it to the address above.

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**.** This payment will not exceed my reasonable and customary charges to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment as stated in my policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.
I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

X_____ Dated: _____
Signature of Policy/Signature of Claimant, if other than Policyholder

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MEMBER AUTHORIZATION FORMS FOR DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

Date: _____

Member's Name: _____ Member's Address: _____

Insurance company: _____ Member's policy #:_____

I hereby authorize **Dr. Robert Marvin/Houston Surgical Specialists** to appeal my insurance company, (Insurance Company Name) _____, concerning services provided on my behalf, as my DESIGNATED REPRESENTATIVE. I hereby authorize my Insurance Company to discuss and disclose any information in connection with the processing of my appeal. Furthermore, I authorize my Insurance Company to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism, drug abuse, mental disorder and HIV status as it relates to my examination, treatment and hospital and confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law.

This authorization is valid for my dates of services provided by the doctor.

X_____
Signature of Member or Legal Guardian/Representative

Designated Representative Printed Name _____

Signature of Witness _____ Printed Name _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO **ROBERT MARVIN M.D- HOUSTON SURGICAL SPECIALISTS** FOR HIS/HER SERVICES **Initial** _____ **Dated:** _____