# Authorization to Bill

LifeMed Alaska, LLC
PO Box 190026
Anchorage, Alaska 99519
fax 907.563.6636

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by LifeMed Alaska now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by LifeMed Alaska, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to LifeMed Alaska any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to LifeMed Alaska. I authorize LifeMed Alaska to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to LifeMed Alaska and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by LifeMed Alaska, now, in the past, or in the future.

Signature _____ Date _____

*If signed by person other than patient please provide relationship to patient* _____

**Please provide all of the following as applicable:**

**Medicare Number:** _____ **Medicaid Number:** 060

## Primary Insurance Carrier Information

**Name of Carrier:** _____
**Address of Carrier:** _____
**City, State Zip:** _____
**Policy Number:** _____
**Group Number:** _____
**Effective Date:** _____
**Name of Insured:** _____
**Birthdate of Insured:** _____
**Employer of Insured:** _____

**Relation to Patient:**
- ○ Self
- ○ Spouse
- ○ Dependent

**Nature of Insurance:**
- ○ Group Insurance
- ○ Medicare Replacement
- ○ Workers Compensation
- ○ Automobile Insurance

## Secondary Insurance Carrier Information

**Name of Carrier:** _____
**Address of Carrier:** _____
**City, State Zip:** _____
**Policy Number:** _____
**Group Number:** _____
**Effective Date:** _____
**Name of Insured:** _____
**Birthdate of Insured:** _____
**Employer of Insured:** _____

**Relation to Patient:**
- ○ Self
- ○ Spouse
- ○ Dependent

**Nature of Insurance:**
- ○ Group Insurance
- ○ Medicare Replacement
- ○ Workers Compensation
- ○ Automobile Insurance

***No insurance or questions about completing this form? please contact us 907.249.8400 – extension 2***