RX# **PATIENT:**

Independent Diagnostic Testing Facility (IDTF)	**Home Medical Equipment Supplier(s)**
IDS- Instant Diagnostic Systems, Inc. 1740 4th Ave SE, Decatur, AL 35601 Phone: 800-355-0691	

Patient Insurance and Release Form Instructions: Patient is required to complete ALL applicable fields below as they appear on your insurance card. Carefully read the Authenticity Statement and Assignment of Benefit and sign and date the appropriate line. Read the Medical Release statement and optionally sign if you agree with the statement.

Your Name: _____ DOB: ____/____/_____ Gender: _____

Your Address: _____ City: _____ State: ___ Zip:_____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance Company and Plan: Subscriber ID/Medicare #: **Complete below from insurance card if NOT Medicare** Subscriber Name: Subscriber Date of Birth: Relationship to Subscriber (circle): Self Spouse Child Group # (if applicable): Claims Address (back of card): Claims Phone # (back of card):	**Note:** IDS may not be able to bill all secondary insurance providers & plans. Patient may be required to self file claims in some cases. Insurance Co/Plan: ID/Subscriber #: Subscriber Name: Subscriber Date of Birth: Claims Address (back of card): Claims Phone # (back of card):

AUTHENTICITY STATEMENT & ASSIGNMENT OF BENEFIT

SECTION I. AUTHENTICITY: I, the undersigned, certify that I am the recipient of the test performed. I certify that I was provided instruction by the IDTF listed above. I also certify that I did not tamper with, or attempt to alter, this test or the results therein, in any way. To the best of my knowledge, I also certify that no one else has tampered with or altered this test, and it will be transmitted to the above listed IDTF entirely in its original form.

SECTION II. **ASSIGNMENT OF BENEFIT:** I, the undersigned, hereby authorize and release the IDTF designated above to bill my insurance and/or Medicare on my behalf for the costs of this testing. Further, I authorize and request my insurance carrier to pay directly to the above-named IDTF, the amount due to me under the terms of my policy, as a result of medical service rendered by that IDTF. I understand that I am financially responsible for any claim denial, deductible or co-payment and agree to make payment to the IDTF at the time of billing. I understand if I do not have insurance coverage or my insurance coverage lapses I will be responsible for the full monetary amount testing charges from the IDTF.

SIGN HERE _____ _____

Patient Signature or Legal Representative (SIGNATURE REQUIRED) **Date**

_____

If Signed by Legal Representative, Print Name and Relationship Above

MEDICAL RECORDS RELEASE

I, the undersigned, authorize the IDTF above to release documents related to and including results of this test, from my medical records file to the company/companies listed above as the "Home Medical Equipment Supplier(s). I also authorize the "Home Medical Equipment Supplier(s)" to discuss with my physician any present or future treatment and/or follow-up services that may be a result of this test.

SIGN HERE _____ _____

Patient Signature or Legal Representative (Signature Optional) **Date**