



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

*Public Health Service, Indian Health Service  
White Earth Indian Health Center*

**Business Office**



**SIGNATURE FORM**

**MEDICARE / MEDICAID**

**PRIVATE INSURANCE**

FOR IHS ONLY  
HRN \_\_\_\_\_

**AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF BENEFITS**

**Patient's Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

I hereby assign to the Indian Health Service (IHS) such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the Indian Health Service.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of any medical insurance benefits be made to the White Earth Health Center. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

*I understand that any checks received by me for services provided at the White Earth Health Center will be turned over to the Business Office.*

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(If patient is a minor Parent/Guardian)**

*\*\*PRIVACY ACT OF 1974, P.L. 93-570\*\* I understand that the information given by me and/or collected is necessary for the Indian Health Service staff of I.H.S. contractor to provide services for my health and well-being. Furthermore, I have been informed that my health record or any portion of the records shall not be disclosed to another agency or person unless specified as routine use (listed on the "WHY WE ASK QUESTIONS" notice) or without my signed consent. I certify that the information given is true and correct.*