

BOON-CHAPMAN

P.O. Box 9201 / Austin, TX 78766
512-454-2681

1. Employer's Name: _____
2. Employee's Social Security Number: _____ Group Number: _____
3. Patient's Name: _____ Relationship: _____
4. Was treatment the result of an occupational injury? Yes No
5. Was treatment the result of an accident? Yes No
6. If yes, please state below how, where, and when the accident occurred: _____
7. Is patient covered by any other group medical plan? Yes No
8. If yes, give plan number, name, address, and phone number of plan sponsor: _____
9. Make benefits payable to: Me Provider (If you have assigned benefits, we must pay the provider.)

Authorization to Release Information:

I hereby authorize the physician/provider to release any information acquired in the course of my or my dependent's examination or treatment. I understand that such information will be used by Boon-Chapman for the purpose of verifying that the services charged for were provided and that I or my authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim, unless revoked in writing by me or my legal representative. The information I have provided on this form is true and correct to the best of knowledge. I agree that a photographic copy of this authorization shall be as valid as the original.

Signature of patient (or parent, if patient is a minor)

50053(12/95)

Date