



ALABAMA ORTHOPAEDIC CLINIC, P.C.

ALABAMA MEDICAL ASSISTANCE PLAN - TITLE XIX
FORM XIX-TPD-1-76
MEDICAID AUTHORIZATION ASSIGNMENT

DATE: _____

ATTACHMENT A

I. Patient's Name: _____ Medicaid #: _____

II. Provider: _____

III. TO BE COMPLETED IF INSURANCE INVOLVED:

A. Name of Insurance Company: _____

B. Address of Insurance Company: _____

C. Policy #: _____ Policyholder: _____

D. Name & Address of Employer if Group Insurance: _____

IV. TO BE COMPLETED IF SERVICES RENDERED AS A RESULT OF AN ACCIDENT:

A. Date of Accident: _____ Location: _____ (LIST CITY & COUNTY FOR AUTO ACCIDENT)

SITE (HOME, SCHOOL, ETC) & ADDRESS FOR OTHER TYPE _____

B. Describe Accident: _____

C. If auto accident, give name & address of driver(s): _____

D. Was auto insurance carried? Yes _____ No _____ (If yes, complete item III)

E. If school accident, was school insurance carried? Yes _____ No _____ (If yes, complete item III)

F. Has an attorney been retained? Yes _____ No _____ Name of attorney _____

V. COMPLETE THE FOLLOWING IF ANY MEMBER OF YOUR HOUSEHOLD IS EMPLOYED:

Employee: _____ Relationship: _____

Employee: _____ Address: _____

II. TO BE COMPLETED IF THERE IS OTHER INSURANCE AND/OR IF AN ACCIDENT WAS INVOLVED:

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Alabama Medical Services Administration, and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the Alabama Medical Services Administration all claims against third parties, including tortfeasors and insurance companies, who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid. I also, assign all rights in any settlement made by me and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid, whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Alabama Medical Services Administration. I permit a copy of this Authorization and Assignment to be used in place of the original

SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS UNDER 19)

WITNESS SIGNATURE BY MARK MUST BE WITNESSED

SIGNATURE OF POLICY HOLDER

WITNESS SIGNATURE BY MARK MUST BE WITNESSED

DATE