Medical Care of Boston Management Corporation

Authorization and Insurance Waiver Form

Authorization to pay insurance benefits:

I hereby direct my insurance carrier to pay Medical Care of Boston Management Corporation (MCB) physician insurance benefits otherwise payable to me.

Signature **Date**

If you are a Member of a Managed Care Plan:

I understand that I have an obligation to get a referral for specialty service from Primary Care Physician prior to making an appointment. If a referral is not received by my specialist, I understand that I may be responsible for full payment of services received should this be deemed by my health plan.

Signature **Date**

Authorization for Release of Information:

I hereby authorize Medical Care of Boston Management Corporation (MCB) to release billing and medical record to my insurance carrier and legal representative for medical services rendered to me by the physicians of MCB.

Signature **Date**