

Surgery & Medicine of the Foot & Ankle



Richard R. Moy, DPM, Inc

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INSURANCE AUTHORIZATION

I, the undersigned, certify that I have insurance coverage and authorize Dr. Richard R Moy to have all claims processed on my behalf under the insurance benefit plan level, either PPO or Out-of-Network.

I, certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. _____ all insurance benefits, if any,
otherwise payable to me for services rendered. I authorize the use of this signature on all
insurance submissions.

I understand that I financially responsible for any co-payment, co-insurance, deductible
and other charges whether or not paid by insurance.

Patient Name (Printed)

Patient or Responsible Party Signature

Date