Telephone 434-352-3003

Fax: 434-352-5005

Mailing Address:
PO Box 666
Appomattox, VA 24522

Appomattox
Medical Center

Physical Address:
181 Old Courthouse Road
Appomattox, VA 24522

www.appomattoxmedicalcenter.com

Name of Beneficiary ____

Insurance Carrier ____

Identification Number ____

Group Number ____

I request that payment of authorized insurance benefits be made on my behalf to Dr. Larry F. Smith, M.D., P.C. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of information necessary to pay the claim. If, I have no health insurance coverage, my signature authorizes the releasing of the information to the insurer or agency shown. Patient /responsible party is responsible for the deductible, coinsurance, and non-covered services.

Coinsurance and deductibles are based on the charge determination of the beneficiary's carrier.

______________________________ ______________________________

Beneficiary Signature Date