TransCare Mobile Health Service
160 West Street, Milford, MA 01757
Phone: 508-473-CARE (2273)
Fax: 508-473-2275

Authorization for Service

Facility: _____

Resident's Name: _____ **Room #:** _____

We are committed to providing the best comprehensive, quality health services to our residents. We offer in-house ancillary services. We have chosen ***TransCare*** *Mobile Health Service* to be our primary provider for these services.

Please indicate your preference of service:

Audiology	**Yes** _____	**No** _____
Dental	**Yes** _____	**No** _____
Optometry	**Yes** _____	**No** _____
Podiatry (Foot Care)	**Yes** _____	**No** _____

Financially responsible person (for non-covered services)

Requires prior approval? Yes _____ No _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: 1. (____)_____ 2. (_____)_____

Relationship to resident: _____

Authorization: I authorize the release of all necessary medical and insurance information to secure payment for services provided. I hereby assign all insurance benefits to the ***TransCare*** *mobile health service* provider for their services rendered for the above resident. This assignment includes any benefit payable by Medicare, Medicaid, and other health insurance programs of which the resident is a beneficiary.

Managed Care Patients: I understand that it is my responsibility to have proper authorization from my primary care physician prior to each date of service. If I do not have the proper authorization, I understand that I may be denied treatment or billed accordingly. I further understand that it is my responsibility to insure the provider is on the insurance plan.

Signature: _____ **Date:** _____