PEDIATRIC GASTROENTEROLOGY OF NORTHERN VIRGINIA
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INSURANCE AUTHORIZATION FORM

I hereby authorize ***Benjamin I. Enav, MD, LLC*** to apply for benefits on my behalf for covered services rendered. I hereby authorize payment of all Medical Insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to ***Benjamin I. Enav, MD, LLC*** for services rendered. I further authorize the release of information needed in processing my insurance. I certify that the information I have reported with regard to my insurance is correct. I understand I am financially responsible for charges not paid by my insurance company. Should it be necessary to refer this account to collection, the undersigned will be responsible for the account balance, attorney's fees and any collection costs.

Most managed care insurance plans require referrals from your primary care physician. I agree that it is my responsibility to obtain the referral and provide it at the time of the appointment, if referral is not provided I will be liable for any charges incurred that my insurance will not cover.

I understand the above and accept full responsibility. The most current version of this form can be found on our website.