AUTHORIZATION FOR USE OF SIGNATURE ON FILE

FOR CLAIM AUTHORIZATION

_____ _____

Enrollee
Social Security Number

Enrollee Name

I, _____, authorize _____

Enrollee Name Provider Name

to mark the section "ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE"

This section authorizes :

1) The release of any medical information necessary to process this claim.

2) Payment of medical benefits to the undersigned physician or supplier of services described below.

This authorization will remain in force until terminated in writing by the enrollee

_____ _____

Enrollee Signature Date

6/18/93 dp