

# Abbas Motazedi, M.D.

Please Print Clearly

Date \_\_\_\_\_

PATIENT NAME (First) _____ (Middle) _____ (Last) _____			Date of Birth _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address _____		Apt. No. _____	City _____	State _____	Zip _____
Employer _____				Social Security No. _____	
Spouse/Parent Name _____				Employer _____	
Referring Physician _____					Work Phone _____
MEDICARE Part B <input type="checkbox"/> Yes <input type="checkbox"/> No      BLUE SHIELD <input type="checkbox"/> D.C. <input type="checkbox"/> Maryland <input type="checkbox"/> Other _____					
ID. Number _____		ID. Number _____		Group Code _____	
OTHER OR SECONDARY INSURANCE			POLICY HOLDER NAME		
Company Name _____		ID. Number _____		Address _____	
MEDICAID					
<input type="checkbox"/> D.C. <input type="checkbox"/> Maryland		ID. Number _____		Effective Date _____	

## Patient Insurance Authorization and Assignment

I, \_\_\_\_\_, hereby authorize Abbas Motazedi, M.D. to apply for benefits on my behalf for services rendered by Abbas Motazedi, M.D., and request that my payments from Medicare, Blue Shield of D.C., Blue

Shield of Maryland, and/or \_\_\_\_\_ be made directly to \_\_\_\_\_  
Name Insurance Co.

Abbas Motazedi, M.D. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent(s): Blue Shield of D.C., Blue Shield of Maryland, Social Security Administration and Health Care Financing in case of Medicare Part B

benefits, and/or \_\_\_\_\_ I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.  
Name Insurance Co.

HMO Insurance Waiver: I understand that if I do not present a referral (Authorization) from my Primary Care Physician before receiving services from specialist physician (Dr. Motazedi), I am fully responsible to pay in full for the services rendered and I waive any such claim to be submitted to my insurance carrier for these services. I authorize Dr. Motazedi to bill me for any Medicare or insurance none cover Medical services.

**Abbas Motazedi, M.D.**  
1160 VARNUM S.T.N.E.  
Suite #111  
WASHINGTON, D.C. 20017  
Phone : 202-269-0381

Patient Signature \_\_\_\_\_

Patient Account Number

Date: \_\_\_\_\_