Humana®

Humana Access® Visa® Easy Pay Consent Form

Patient name: _____
Last First Middle initial

I authorize: _____
Provider name

- To charge my Humana Access Visa debit card for my member responsibility as determined by Humana.
- To credit my spending account when an overpayment of my member responsibility has occurred.

____ This visit only, not to exceed $_____

____ All visits in the next year, beginning ____/____/____, not to exceed $_____

____ Recurring charges, date(s) of service ____/____/____ to ____/____/____, not to exceed $_____ ___ monthly ___ semimonthly ___ weekly ___ per visit

_____ _____
Cardholder name Cardholder signature

_____ _____
Card number Card expiration date

I assign my insurance benefits to the provider listed above. I understand this form is valid for this policy year, unless I cancel the authorization through written notice to the health care provider.

____/____/____ _____
Today's date Signature