I request that payment of authorized Medicare and/or insurer benefits be made to me or on my behalf to _____ for services furnished to me by said physician. I authorize _____ to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services.

I understand that if, under Medicare program guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the Third Party Payor.

_____ _____

Name of Patient Date

I request that payment of authorized Medigap (secondary insurance) benefits be mand either to me or on my behalf to _____. I authorize any holder of medical information about me to release to: _____ any information

Name of Secondary Insurance

needed to determine these benefits payable for related services.

_____ _____

Name of Secondary Insurance Policy Number

_____ _____

Subscriber if different than patient Group Number if applicable

_____

Address of Insurance Carrier

If there is a third insurance, please indicate below:

_____ _____ _____

Carrier Policy Number Group Number