MEDICARE INFORMATION/AUTHORIZATION

Please print your name exactly as it appears on your Medicare card:

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Please print your Medicare Number exactly as it appears on your Medicare card. Be sure to include any letter(s) after the number.

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Please Sign So We May Have Your Medicare Authorization on File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: ____/____/____ Signature: ____________________________________

Please Sign So We May Have Your <u>Supplemental Authorization</u> on File:

I request authorized SECONDARY benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the SECONDARY carrier any information needed to determine these benefits or the benefits payable to related services.

Date: ____/____/____ Signature: _____________________________________

Payment Policy

Medicare: We are participating providers of the traditional Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% coinsurance. We do file with secondary/ supplemental carriers. However, in the event that the secondary does not pay within 60 days, patient will be balance billed.

NOTE: If you have recently joined (or changed to) a Medicare Advantage product, please let our staff know so we can update your records and advise you if we are participating providers.

Please present Medicare and secondary insurance card(s), photo ID,
and pharmacy card to the receptionists so copies may be made.