

MEDICARE PATIENT INFORMATION

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



Name as it appears on your Medicare Card: _____

Medicare #: _____

Please sign below so we 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 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. Medicare assignment of benefits regulations apply.

Patient Name (Please Print)

X _____ Date: _____
Signature

SUPPLEMENTAL INSURANCE

Policy #: _____ Group #: _____

Please sign so we have your supplemental insurance authorization on file:

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

X _____ Date: _____
Signature