family foot docs

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ______________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents and information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

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Beneficiary Signature   Date