☐ Richard A. Burgett, M.D., F.A.C.S.
☐ Thomas C. Ciulla, M.D.
☐ Robert D. Deitch, M.D.
☐ Neil P. Finnen, M.D.
☐ Kathryn M. Haider, M.D.
☐ Scott R. Hobson, M.D., F.A.C.S.
☐ Frank N. Hrisomalos, M.D.
☐ Nicholas F. Hrisomalos, M.D.
☐ Stephen M. Johnson, M.D.
☐ Kevin E. Lai, M.D.
☐ Ronald T. Martin, M.D., F.A.C.S.

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☐ Raj K. Maturi, M.D.
☐ John T. Minturn, M.D.
☐ Daniel E. Neely, M.D.
☐ Hemang C. Patel, M.D.
☐ David A. Plager, M.D.
☐ Gavin J. Roberts, M.D.
☐ Stephen J. Saxe, M.D.
☐ Milan Shah, M.D.
☐ Derek T. Sprunger, M.D.
☐ Robert M. Troyer, M.D.
☐ Michael G. Welsh, M.D., F.A.C.S.

Patient's Medicare Authorization

Note: To be signed only by patients who are covered by Medicare

Patient Name: _____

Patient's Medicare Number: _____

I request the payment of appropriate, authorized Medicare benefits be made on my behalf to ***my physician/provider (checked above*)** for any services furnished to me by this physician/provider. Additionally, I authorize my medical provider to release any information about me to the Health Care Financing Administration, Centers for Medicare/Medicaid, and/or their agents, that might be needed to determine any benefits payable for the services furnished.

I will also permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ ***Date:*** _____

Patient's Third Party Payer and/or Medicare Supplement Authorization

I request the payment of appropriate, authorized benefits be made on my behalf to ***my physician/provider (checked above)*** for any services furnished to me by this physician/provider. Additionally, I authorize my medical provider to release any information about me to the insurance carrier and/or third party medical claims administrator, covering my at the time medical services are provided, that might be needed to determine any benefits payable for the services furnished.

I will also permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ ***Date:*** _____