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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:*** _____