



Richard A. Burgett, M.D., F.A.C.S.  
Thomas C. Ciulla, M.D.  
Robert D. Deitch, M.D.  
Scott R. Hobson, M.D., F.A.C.S.  
Nicholas F. Hrisomalos, M.D.  
Stephen M. Johnson, M.D.  
Ronald T. Martin, M.D., F.A.C.S.  
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.  
Valerie Ann Purvin, M.D.  
Gavin J. Roberts, M.D.  
Derek T. Sprunger, M.D.  
Seema V. Sundaram, M.D.  
Robert M. Troyer, M.D.  
Michael G. Welsh, M.D., F.A.C.S.

**PATIENT'S MEDICARE AUTHORIZATION**  
**ONLY to be signed by patients who are covered by Medicare.**

**Patient Name** \_\_\_\_\_

**Patient's Medicare Number** \_\_\_\_\_

I request that payment of authorized Medicare benefits be made to either or on my behalf to \_\_\_\_\_ for any services furnished me by that physician / supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

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

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

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**PATIENTS ADDITIONAL or SUPPLEMENTAL AUTHORIZATION**

**Patient Name** \_\_\_\_\_

**Patient's Policy/Member Number** \_\_\_\_\_

I request that payment of authorized benefits be made to either or on my behalf to \_\_\_\_\_ for any services furnished me by that physician / supplier. I authorize any holder of hospital or medical information about me to release \_\_\_\_\_ (company) any information needed to determine these benefits or the benefits payable for related services.

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

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_