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DR. JENNIFER CROSS DR. STEPHANIE SHOULTS DR. DEVIN DESPAIN DR. CRYSTAL CARRINGTON-HELLIER

MEDICARE AUTHORIZATION

I request that **payment of authorized Medicare benefits** be made either to me or on my behalf to Dr. _____ for any services furnished to me by my physician. **I authorize** any holder of 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 understand my signature requests that payment be made and authorizes the 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 the 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, co-insurance, and noncovered services.** Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____