

Patient Name: _____

Date of Birth: _____

For Medicare Patients Only

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services or its intermediaries or Carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductibles, coinsurance and any non-covered services as determined by Medicare.

Patient Signature: _____

Date: _____

Medicare Supplemental Insurer's MEDIGAP Assignment of Benefits

Section 4081 of the Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medicare Supplemental (MEDIGAP) insurance benefits.

I understand my signature gives authorization for my physician to bill claims directly to my recognized MEDIGAP insurance carrier and for payments to be received directly. This also allows for medical information to be forwarded to the insurance carrier as necessary.

The Explanation of Medical Benefits received from Medicare will display the following message to notify you that claim has been submitted to your MEDIGAP Carrier - *"Because you assigned MEDIGAP benefits, information regarding your claim will be sent to your private insurer within 30 days."*

I also understand that any deductibles, coinsurance and non-covered services will be my responsibility.

Patient Signature: _____

Date: _____