MEDICARE BENEFICIARY AUTHORIZATION

Name of Beneficiary Medicare No.

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Cola/Dr. Scola/Dr. Bittenbender/Dr. Walker** for any services furnished me by that physician or supplier. 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."

Beneficiary Signature Date

MEDIGAP

(Medicare Patients Only)

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to **Dr. Cola/Dr. Scola/Dr. Bittenbender/Dr. Walker** for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to _____ (carrier name) any information needed to determine these benefits payable for related services.

Beneficiary Signature Date

RELEASE OF MEDICAL BENEFITS AND RECORDS

Name of Patient Claim No.

"I authorize payment of Medical benefits to **Dr. Cola/Dr. Scola/Dr. Bittenbender/Dr. Walker** for services rendered. I understand that services are rendered to me and not to insurance carrier on my behalf. The insurance carrier will not relieve me from my financial responsibility to **Dr. Cola/Dr. Scola/Dr. Bittenbender/Dr. Walker**. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

Beneficiary Signature Date