

MEDICARE PATIENTS ONLY

Please read each of the following and answer as they apply to you.

YES

NO

Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)

Do you or your spouse work full time, if so, do you have coverage through the insurance at that job?

Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?

Do you have Medicare due to a disability?

Are you covered by the Federal End Stage Renal Disease Program?

Is the illness or injury you are coming to this office for the result of work-related causes?

Do you have MEDICAID coverage supplement to your Medicare?

Do you have medical coverage supplement to your Medicare?

Is this Medicare an HMO?

If you answered YES to any of the above questions: _____

Name of Company

Insured's Name: _____

Policy Number: _____ Group Number: _____

Please sign so we may have your Medicare authorization on file:

I authorize any holder of medical or the other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier of any information needed for this or 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 either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Signature _____

Date _____