

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to **SOUTHWEST FOOT INSTITUTE** for services rendered. I hereby authorize the doctor to release to the Center of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other insurance is indicated my signature authorizes 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, copayment, and charges associated with non-covered services. Copayments and deductibles are based upon the charger determination of the Medicare carrier.

If you have a MEDICARE SENIOR product, this replaces your Medicare and you are subject to a copayment, every visit, which is due at the time of service.

Initials _____

If you have a SECONDARY INSURANCE, we will file the claim as a **courtesy** to you. It is our office policy that if the secondary has not paid the 20% within 60 days of our filing the claim, the bill will be sent to you for immediate payment and you will have to get the reimbursement from your Secondary Insurance.

Initials _____

Beneficiary Signature _____ Date ____/____/____