
PATIENT NAME

MEDICAL RECORD # (office use)

AFFILIATED DERMATOLOGISTS, S.C.

MEDICARE & MEDIGAP PATIENTS

MEDICARE

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim.

Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier 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 either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that I can revoke this authorization in writing at any time.

Signature of Patient as it appears on Medicare card

Date

MEDIGAP

If you have a **supplemental policy** and it is a **MEDIGAP** policy to which Medicare automatically "crosses over," we are required to keep a separate signature on file.

Please read and sign the following statement:

I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient as it appears on Medigap card

Date

