Medicare Authorization to Release Information for Medicare Payment

SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made to Midwest Retina Associates, Inc. for services provided. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly HCFA) and its agents, any information needed to determine these benefits or these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have additional insurance coverage, my signature authorizes releasing of the information to that insurer or agency. 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature ______________________________________ Date _______________________