MEDICARE AUTHORIZATION (FOR MEDICARE PATIENTS ONLY)

NAME_____

MEDICARE
NUMBER_____

I request that payment of Authorized Medicare benefits be made on my behalf to Mid-Atlantic GI Consultants, P.A. (MAGIC) for any services rendered to me by MAGIC. I authorize any holder of medical information about me to release my information to the Health Care Financing Administration and its agents in order to determine my benefits that are payable for services by MAGIC.

I understand that my signature requests that payment(s) be made to MAGIC and authorizes release of my medical information which is necessary to pay the claim (s). If other health insurance is indicated on the HCFA 1500 Claim Form or on an electronically submitted claim, my signature authorizes release of information to the insurer or agency shown.

In Medicare-assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I understand that I am responsible for the deductible, co-insurance and non-covered services. The co-insurance and deductible are based upon the charge determination for the Medicare carrier.

Signature of patient or patient's representative Date