

OLD TOWN ENDOSCOPY CENTER
LIFETIME MEDICARE SIGNATURE ON FILE

Name of Patient

Medicare Claim Number – HICN

I am giving Old Town Endoscopy Center permission to ask for Medicare payments for my medical care.

I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to be released to Medicare and the companies that handle Medicare payment requests.

I understand that the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) is the government Medicare agency.

I request that payment of authorized Medicare benefits be made either to me or to Old Town Endoscopy Center on my behalf for any services furnished to me by Old Town Endoscopy Center.

I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature

Date

.....
SECONDARY – MEDIGAP SIGNATURE ON FILE

Name of Patient

Medicare Claim Number

Medigap Policy

I am giving Old Town Endoscopy Center permission to ask for Medigap payments for my medical care.

I understand that _____ (insurer) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to be released to _____ (insurer).

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by Old Town Endoscopy Center including it's physicians. I authorize any holder of medical or other information about me to release to _____ (insurer) any information needed to determine these benefits for related services.

Signature

Date