



NOTICE TO MEDICARE PATIENTS

As a Medicare participating provider it is required that we have all or our patients complete this form which is the standard authorization that allows us to bill Medicare on your behalf each time you receive services from (insert practice name). When you complete this form, we can bill Medicare directly, receive Medicare’s portion of the reimbursement, and then bill you or your secondary insurance for the uncovered services and any balance for which you are directly responsible according to Medicare rules and regulations.

_____ Name of Beneficiary/Member (Print name as it appears on your card)		_____ Medicare Number	
		_____ Patient ID Number	
“I request that payment of authorized Medicare benefits be made on my behalf to _____, or any of its individual providers, for any services furnished to me by any of its individual providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me or my legal representative in writing”			
_____ Medicare Patient Signature		_____ Date (Must complete)	
“I request that payment of authorized Medigap benefits be made to _____, or any of its individual providers for any services provided to me by any of its individual providers. I authorize any holder of Medicare information about me to release to my Medigap Insurer (named below) any information needed to determine these benefits payable for related services.”			
_____ Medicare Patient Signature		_____ Medicare Number	
Name of Medigap Insurance: _____		_____ Date (Must Complete)	
Policy Number: _____			
Person Holding Medigap Insurance: _____			