

ADVANCED HEART CARE, P.A.

SIGNATURE ON FILE (Medicare Patient's Only)

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Heart Care, P.A. for any services furnished to me by the Association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the 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 "other health insurance" is indicated on the HFCA-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME

PATIENT'S SIGNATURE

DATE

PATIENT'S MEDICARE #

MEDICARE-MEDIGAP AUTHORIZATION (For Medicare Patient's Only)

I request that payment of authorized Medigap (Medicare Supplement Insurance Carrier) benefits be made to Advanced Heart Care, P.A. for any services furnished to me by these providers. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits or the benefits for related services.

PATIENT'S SIGNATURE

DATE