COASTAL
DERMATOLOGY & SURGERY CENTER, P.A.

MEDICARE BENEFICIARY FORM

Coastal Dermatology & Surgery Center, P.A. is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare Card Date

If you have a supplemental policy or secondary coverage, we are required to keep a separate signature on file.

I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on Insurance Card Date

Please present your insurance cards to the receptionist for photocopying.

Thank you for choosing this office to assist in your care.