

MILWAUKEE SURGICAL SPECIALISTS, S.C.

MEDICARE AUTHORIZATION

Patient's Name: _____

Patient's Medicare Number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Milwaukee Surgical Specialists, S.C., its physicians and its physician assistants for any services furnished to me by that physician/supplier. 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 to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature hereby authorizes the release of the information to the applicable insurer or agency. In Medicare assigned cases, the physician or supplier has agreed to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature: _____ **Date:** _____



MEDIGAP AUTHORIZATION

(Fill out if you have Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplement policy is a health insurance policy, or other health benefit plan, offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.)

Patient Name: _____

Medigap Insurance Company: _____

Patient's Medigap Number: _____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Milwaukee Surgical Specialists, S.C., its physicians and its physician assistants for any service furnished to me by that participating physician/supplier. I authorize any holder of hospital or medical information about me to release to the Medigap Insurance Company listed above.

I permit a copy of this authorization to be used in place of the original. This authorization is in force until it is either canceled or changed by me.

Patient's Signature: _____ **Date:** _____