

Lifetime Beneficiary Claim Authorization
"Signature on File" Requirements

YOUR NAME

Name of Beneficiary _____

MEDICARE NUMBER

HIC Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Memorial Bone & Joint Clinic for any services furnished me by Memorial Bone & Joint Clinic. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) 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 item 9 of the CMS 1500 form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature **X** _____

Date **X** _____