ASSIGNMENT OF MEDICARE BENEFITS

PATIENT NAME:_____

MEDICARE NUMBER : _____

I request that payment of authorized Medicare benefits be made on my behalf to

COLUMBUS EYE ASSOCIATES

For any service furnished to me by a physician of the group. 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 payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

SIGNATURE: _____

DATE: _____

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to **COLUMBUS EYE ASSOCIATES,** or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer, _____, or any information needed to determine these benefits for related services.

The assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

SIGNATURE: _____

DATE:_____