MEDICARE PATIENTS ONLY

LIFETIME BENEFICIARY AUTHORIZATION

______________________________ (NAME OF BENEFICIARY)

____________________ (HIC NUMBER)

I request payment of authorized Medicare benefits be made either to me or on my behalf to **WEBSTER ORTHOPAEDIC MEDICAL GROUP** for any services furnished me by that physician/supplier. 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 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 HCFA-1500 claim form is completed, my signature authorizes 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ BENEFICIARY SIGNATURE

____________________ DATE

REORDER #01-19819