# Elite Podiatry, P.L.L.C.

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## MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made to me or on my behalf to Elite Podiatry, PLLC for any services furnished me by that practice/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits payable to related services.
I understand my signature below 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 form, or elsewhere on other approved claim forms or electronically submitted claims, 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, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination on the Medicare carrier.

_____ _____

Patient's Name Patient's Medicare number

_____ _____

Patient's Signature Date

## PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method bye the listed provider. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-pays, co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

_____ _____

Patient's Name Insurance company name

_____ _____

Patient's Signature Insurance policy number

_____ _____

Date Insurance group number