

MEDICARE PATIENTS

Statement to Permit Payment of
Medicare Benefits to Provider
Physicians and Patients

I request that payment of authorized Medicare benefits be made wither to me or on my behalf for any services furnished me by Nephrology Physicians, LLC. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature

Date

Printed Name

Medicare Number

I request that payment of authorized MediGap benefits be made either to me or on my behalf to Nephrology Physicians, LLC for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release said information to my MediGap insurer to determine if these benefits or benefits payable for related services.

Signature

Date

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COMMERCIAL INSURANCE PATIENTS

I authorize the release of any medical or other information necessary to process a medical claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature

Date