MEDICARE PATIENT REGISTRATION

Please answer the questions below by placing a check in the appropriate column:

Yes	No	
☐	☐	Have you recently joined a Medicare HMO? If yes, identify_____
☐	☐	Are you covered by an HMO / PPO which makes Medicare secondary?
☐	☐	Are you covered under Medical or Medicaid?

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for proper consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____ _____

Printed name Signature Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature Date

Lisa Benest, MD * Randi Rush, DO * Olga Bunimovich, MD
1624 W Olive Ave, Suite B, Burbank, CA 91506 * (818) 729-9149 * fax (818) 729-9119
www.LisaBenestMD.com