504 W. Pueblo, Suite 202
Santa Barbara, CA 93105
t 805-682-6455 f 805-687-1482
contact@luminousderm.com
luminousderm.com

LIFETIME ASSIGNMENT

Name:____

Medicare HIC #____

Medigap Company name _________________________________

Medigap #____

I request that payment of authorized Medicare benefits be made payable on my behalf to Luminous Dermatology for any services furnished to me by Luminous Dermatology. 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. In Medicare assigned cases, the physician or supplier agrees to accepts assignment, which means they agree to accept the charge determination of the Medicare carrier as the full charge and I, the patient am responsible for only the deductible, coinsurance, and non-covered services. I understand coinsurance and deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.

____
Signature Date

ANNUAL MEDIGAP ASSIGNMENT

I request that payment of authorized Medigap benefits be made to Luminous Dermatology for any services provided by their physicians. I authorize any holder of medical information about me to release to the plan named above any information needed to determine these benefits or the benefits payable for related services.

____
Signature Date

____
Signature Date

____
Signature Date

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