Ophthalmology
Physicians & Surgeons, PC

Eye Care
Physicians & Surgeons

# MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Ophthalmology Physicians & Surgeons, PC for any services furnished me by that physician's office. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and it's agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency shown. Ophthalmology Physicians & Surgeons, PC accepts the charge of determination of Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

This is a lifetime authorization. I also authorize benefits be made on my behalf to Ophthalmology Physicians & Surgeons for my co-insurance coverage. This is also a lifetime authorization.

_____

*Signature*

_____ _____

Printed Name Date

You can type in your name and the date, then print the form, sign it and give it to one of our staff.
OR Print the form, fill it in by hand and give it to one of our staff.