

MEDICARE PATIENTS:SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made on my behalf to "Chris R Crawford MD" for any services furnished me by the listed provider/supplier. 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 or the benefits payable to related services.

I understand that my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of 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 provider 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, coinsurance, and the non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patients Name (print)

Date

Patients Signature