Fillmore Eye Clinic, Inc.
1124 10th Street, Alamogordo, NM 88310
Tel. (575) 434-1200, Fax (575) 437-3947

Medicare & Medigap

Beneficiary's Name (Print) _____ Medicare ID Number _____

1. Medicare

I request that payment of authorized Medicare benefits be made on my behalf to Fillmore Eye Clinic, Inc., for services furnished to me by Fillmore Eye Clinic, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the 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. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing information to the insurer or agency shown.

Fillmore Eye Clinic, Inc. accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurances, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature _____ Date _____

2. Medigap

If a Medigap policy or other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made to Fillmore Eye Clinic, Inc. on my behalf.

Signature _____ Date _____