# *EYE CARE FOR TULSA, INC*

## Patient Authorization for Medicare Assignment of Benefits

**Patient Name:** _____

**Medicare Claim #:** _____

I request that payment of authorized Medicare benefits be made on my behalf to Eye Care for Tulsa, INC, Drs. Brister, Stover, Wells, and Beartrack for any services furnished to me by a physician or the group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.

*In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.*

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

***Patient Signature:*** _____

***Date:*** _____

### MediGap or Other Secondary Insurance:

I request that the payment of authorized MediGap benefits be made either by me or on my behalf to Eye Care for Tulsa, INC, Drs. Brister, Stover, Wells, and Beartrack for any services furnished to me by a physician or the group. I authorize any holder of medical information about me to release to my MediGap insurer, or any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

***Patient Signature:*** _____

***Date:*** _____