

MEDICARE
STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS
TO PROVIDER, PHYSICIANS, AND PATIENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable for physician services and other services and goods to the physician or organization furnishing the same. I also authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program for services or goods furnished to me by Scott Orthopedic Center or its agents, employees, or providers be made either to me or to Scott Orthopedic Center. Scott Orthopedic Center has permission to talk to a Medicare entity on my behalf.

SIGNATURE

DATE

I UNDERSTAND THAT CERTAIN APPLIANCES, BRACES, OR SPLINTS MAY NOT BE COVERED UNDER MEDICARE BENEFITS. I AGREE TO BE RESPONSIBLE FOR THE CHARGE FOR THESE ITEMS. I UNDERSTAND THAT I AM FREE TO OBTAIN THESE ITEMS FROM ANOTHER SOURCE.

SIGNATURE

DATE