

PARKSIDE
Internal Medicine

MEDICARE LIFETIME ASSIGNMENT

Name of Beneficiary (Patient) _____

Medicare Number (HIC Number) _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Parkside Internal Medicine** (Physician/Clinic Name) for any services furnished to me by that provider. 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 benefits or the benefits payable for related services.

This authorization is effect until I choose to revoke it.

Signature _____ Date _____

*If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.

MEDIGAP ASSIGNMENT AGREEMENT

Name of Beneficiary (Patient) _____

Medigap Policy Number _____

Medicare Number (HIC Number) _____

I am giving **Parkside Internal Medicine** (Physician/Clinic Name) permission to ask for Medigap payments for my medical care.

I understand that _____ (Name of Medigap Insurer) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to _____ (Name of Insurer)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to **Parkside Internal Medicine** (Physician/Clinic Name) for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (Name of Medigap Insurer) any information needed to determine benefits or the benefits payable for related services.

Signed _____ Date _____