MERITAS HEALTH

MEDICARE/MEDIGAP LIFETIME CONSENT

Patient Name: _____ DOB: _____

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made payable on my behalf to Meritas Health for any services furnished to me by its physicians or clinicians. 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 or the benefits of related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until revoked by me in writing.

_____ _____ _____

Signature of Beneficiary Medicare ID Number Date

Medi-Gap Insurance Lifetime Assignment of Benefits

I, the undersigned, have Medi-gap insurance coverage with _____ (name of insurance carrier) and assign directly to Meritas Health, all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until revoked by me in writing.

_____ _____ _____

Signature of Beneficiary Policy Number Date