Breast Care Specialists AMC
Medicare/Medigap Card

SIGNATURE ON FILE

Name of Patient: _____

HIC# _____

Name of Medigap Insurer (if applicable) _____

Medigap Policy # (if applicable) _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished 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 these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Patient's Signature _____

Date Signed _____