BUCKS
REHABILITATION
SPECIALISTS

MEDICARE SIGNATURE ON-FILE FORM

_____ _____

(Name of Patient) **(Name of Representative)**

Address:_____

_____

Relationship to Patient:_____

Reason Patient Unable to Sign:

_____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. 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 service."

_____ _____

(Patient Signature) **(Date)**

_____ _____

(Representative Signature) **(Date)**

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to **(Name of Medigap Insurer)**_____ any information needed to determine these benefits payable for related services."

"I understand that if I have no Medigap or other supplemental insurance, that I am responsible to pay the annual Medicare deductible and 20% coinsurance that Medicare requires me to pay."

_____ _____

(Patient Signature) **(Date)**

_____ _____

(Representative Signature) **(Date)**

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