ASSIGNMENT OF BENEFITS

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

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in Westgate Family Medicine, including my physician services. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

Printed Name _____ Medicare Number (HICN) _____

I request that payment of authorized MediGap benefits be made either to me or on my behalf to Westgate Family Medicine for any services furnished me by that physician's group. I authorize any holder of medical information about me to release to Westgate Family Medicine any information to determine these benefits or the benefits payable for related services.

Signature_____ Date _____

COMMERCIAL INSURANCE PATIENTS:

I authorize the release of any Medical or other information necessary to process a medical claim. I also authorize payment to be made to Westgate Family Medicine for any services provided to me by that physician group.

Signature_____ Date _____