Relief
Allergy & Sinus Institute

(630) 513-1691
reliefasi.com

MEDICARE PATIENTS:

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patients

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services provided to me by Relief Allergy & Sinus Institute including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Signature ______________________ Date ______________________

Printed Name ______________________ Medicare Number (HICN) ______________________

I request that payment of authorized supplemental benefits be made either to me or on my behalf to Relief for any service physician/provider. I authorize any holder of medical information about me to release to

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(Name of supplemental/secondary insurance)

any information to determine these benefits or the benefits payable for related services.

Signature ______________________ Date ______________________

The first paragraph must be filled out for all Medicare patients.

The second paragraph must be filled out for Medicare patients <u>who have a supplemental plan as secondary</u>. If you are non-participating, then paragraph two is optional if you do not file the supplemental.