Medicare

Lifetime Beneficiary Claim Authorization
(“Signature On File”)

____________________________	____________________________
(Name of Beneficiary)	(Card Number, “HIC Number)

I request that payment of authorized Medicare-Benefits be made on my behalf to Creamer Physical Therapy, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA – 1500 claim form is completed, my signature authorizes releasing of the information and the insurer or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X___________________________	____________________________
Beneficiary Signature	Date