

MEDICARE
Beneficiary Authorization

Name of Beneficiary (Patient)

HIC/Medicare Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Valley Institute of Prosthetics and Orthotics, Inc.** (Supplier) for any services furnished me by 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 payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim forms or electronically submitted claims, my signature below authorizes releasing of the information to the insurance or agency shown. In Medicare assigned cases, the Supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary (Patient)

Date