Intracoastal Internal Medicine, PA

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Medicare Beneficiary Form

___________________________________   ___________________________

Print name as it appears on Medicare card   Medicare Claim Number

I request that payment of authorized benefits be made either to me or on my behalf to Intracoastal Internal Medicine, PA for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and 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 to the insurer or agency shown. In Medicare assigned cases, the physician 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, co-insurance, and non covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare supplier.

___________________________________   ___________________________

Sign name as it appears on Medicare card   Date

Phone: 910-332-0701   Fax: 910-332-0710

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