



AUTHORIZATION OF BENEFITS

Name of Beneficiary: _____

1. MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Planchard Eye & Laser Center, for services furnished to me by Dr. Planchard. 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 or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Planchard Eye & Laser Center accepts 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 deductibles are based upon the charge determination of the Medicare Carrier.

Responsible Party

Date

2. MEDIGAP

If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on behalf of Planchard Eye & Laser Center.

Responsible Party

Date

3. OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to Planchard Eye & Laser Center. I understand that I am financially responsible for any changes whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Planchard Eye & Laser Center. I authorize Planchard Eye & Laser Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Responsible Party

Date