Name: ________________________________

Medicare Number: ______________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Charles H. Boniske for any services furnished me by that physician. 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 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 the information to the insurer or agency shown (i.e. secondary insurance information). In Medicare assigned cases, the physician 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.

_____________________________ _______________
Beneficiary signature date