Hackensack Meridian *Health* Medical Group

NOTICE TO MEDICARE PATIENTS

As a Medicare participating provider it is required that we have all or our patients complete this form which is the standard authorization that allows us to bill Medicare on your behalf each time you receive services from Hackensack Meridian *Health* Medical Group. When you complete this form, we can bill Medicare directly, receive Medicare's portion of the reimbursement, and then bill you or your secondary insurance for the uncovered services and any balance for which you are directly responsible according to Medicare rules and regulations.

_____ _____

Name of Beneficiary/Member
(Print name as it appears on your card)

Medicare Number

_____

Patient ID Number

"I request that payment of authorized Medicare benefits be made on my behalf to _____, or any of its individual providers, for any services furnished to me by any of its individual providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me or my legal representative in writing"

_____ _____

Medicare Patient Signature

Date (Must complete)

"I request that payment of authorized Medigap benefits be made to _____, or any of its individual providers for any services provided to me by any of its individual providers. I authorize any holder of Medicare information about me to release to my Medigap Insurer (named below) any information needed to determine these benefits payable for related services."

_____ _____

Medicare Patient Signature

Medicare Number

Name of Medigap Insurance: _____ _____

Date (Must Complete)

Policy Number: _____

Person Holding Medigap Insurance: _____

For Internal Use Only:

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