

**Medicare Patients Only:**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medial or other information about me to release to the Center of Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that I can revoke this authorization in writing at any time.

Signature as it appears on Medicare card: \_\_\_\_\_ Date \_\_\_\_\_

**Medicare Secondary Insurance (MEDIGAP Policies):**

A MEDIGAP Policy is a supplemental policy that covers the remaining 20% that Medicare does not. If you have such a policy, we are required by Medicare to keep a second signature on file.

I request authorized MEDIGAP benefits be made on my behalf to IKP Family Medicine for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card: \_\_\_\_\_ Date \_\_\_\_\_