Associates in Vascular Care

Notice to Medicare Patients:

As a Medicare participating provider it is required that we have all our patients complete this form which is standard authorization that allows us to bill Medicare on your behalf each time you receive services from *Associates in Vascular Care.* When you complete this form, we can bill Medicare directly, receive Medicare's portion of the reimbursement, and the 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.

"I request and authorize that payment be made to Medicare benefits on my behalf. I authorize any holder or medical information about me to be released 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."

_____ _____

Signature of Patient or Representative *Date Notice Signed (**Must Complete**)*

_____

Medicare Number

"I request that payment be authorized to my secondary insurance benefit. I authorize any holder of Medicare information about me to be released to my secondary insurer (named below) any information needed to determine these benefits payable for related services."

Name of Secondary Insurance: _____

Policy ID Number: _____

_____ _____

Signature of Patient or Representative *Dated Notice Signed (**Must Complete**)*