ABILENE DERMATOLOGY AND SKIN SURGERY CENTER, PC

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Phone: (325) 672-5603 Fax: (325) 672-6570

ASSIGNMENT OF BENEFITS FORM
MEDICARE / TRICARE / TRIWEST PATIENTS

Patient Name: ____ Patient MRN: ________________________

Patient Date of Birth: ________/________/__________ Patient SSN: ______________________________

MEDICARE

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 medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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 of Patient as it appears on Medicare card Date

SUPPLEMENTAL POLICY IN ADDITION TO MEDICARE IS CALLED MEDIGAP

If you have a supplemental policy in addition to Medicare, this is a MEDIGAP policy, and we are required to keep a separate signature on file. Please read and sign the statement that follows:

I request authorized Medigap/Secondary Insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to be released to my Medigap/Secondary Insurance carrier any information needed to determine these benefits or the benefits payable for related services.

____ __________________________________

Signature of Patient as it appears on Medigap card Date

TRICARE / TRIWEST

This office is required to keep your signature on file authorizing us to file claims to Tricare and Triwest on your behalf and to release information to that payor if they require it for the proper consideration of a claim. In addition, we are required to obtain your signature each year on this form. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to Tricare or Triwest or its intermediaries or carrier any information needed for a 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 Tricare and Triwest assignment of benefits apply. I understand that I can revoke this authorization in writing at any time. This Assignment of Benefits will be valid for a period of one year beginning on ________ / ________ / ________ and ending on ________ / ________ / ________.

____ __________________________________

Patient Signature as it appears on Department of Defense card Date