MEDICARE PATIENTS ONLY

If your insurance coverage includes Medicare (as either a Primary or Secondary insurance), please fill out the page below.

MEDICARE INFORMATION

	Please circle:	
Are you covered by a spouse employer group plan?	Y	N
Are you an end stage renal disease beneficiary?	Y	N
Are you a disabled beneficiary under age 65?	Y	N
Are you covered under black lung benefits?	Y	N
Are you a Veteran's Administration beneficiary?	Y	N

I request that payment of authorized benefits be made on my behalf to William Purtill, M.D., PC for services furnished to me by the provider.
I authorize any holder of medical information about me to release to Empire Medical Services any information needed to determine these benefits or the benefits payable for related services.

Patient or Authorized Signature: _____

Date:_____