

AUTHORIZATION

I understand that I am financially responsible for the services provided to me or my family members by this health service provider or supplier regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the health service provider or supplier or its billing agent for any services provided to me by the health provider or supplier. I authorize and direct any holder of medical information or documentation about me to release to the Center for Medicare and Medicaid Services and its carriers and agents, as well as to this health provider or supplier and their billing agents, any information or documentation needed to determine these benefits payable for any services provided to me by the health service provider, both now or in the future. A copy of this form is as valid as the original. I also agree to immediately remit to this health service provider any payments that I receive directly from any source for the services provided to me, now or in the future.