



**Lifetime Beneficiary Claim Authorization and Information Release**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Medicare ID Number

I hereby assign/request that payment of authorized Medicare benefits be made directly to Wendy E. Roberts, M.D for services rendered to me by her.

I understand that because Dr. Roberts accepts Medicare assignment, she agrees to accept the Medicare allowed amount as payment in full. I understand that once Medicare has paid their portion, a coinsurance balance of 20% of their allowed amount remains. I understand that claims will be submitted to my Secondary Insurance by Dr. Roberts for this balance. If my Secondary Insurance does not automatically coordinate benefits with Medicare, I accept responsibility for claim submission to them for subsequent payment of the 20% coinsurance balance. If I elect not to submit my claim to my Secondary Insurance for payment of the 20% coinsurance, I accept responsibility for the payment of this balance in full. I understand that I am responsible for the Part B deductible (if not paid by my Secondary Insurance) and all non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand that if Dr. Roberts has received no payment from Medicare ninety (90) days after billing Medicare, I am fully and personally responsible for paying the charges to Dr. Roberts.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to process the claim.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date