SIGNATURE ON FILE
ONE TIME AUTHORIZATION

Russell N.A Cecil, MD, PhD.
Medicare Provider #54654B
Medicare DME #0210050001

Gerald J. Ortiz, MD
Medicare Provider #54654D

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

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 related medical 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____

Signature Date

_____

Health insurance Claim#

MEDIGAP ASSIGNMENT OF BENEFITS

_____ _____

Name of Beneficiary Medigap Insurer

_____ _____

Medicare Insurance claim# Medigap Policy #

I request that payment of authorized Medigap benefits be made either to me or on my behalf to MOHAWK VALLEY ORTHOPEDICS, P.C. (Russell N.A. Cecil, MD, PhD., or Gerald J Ortiz, MD) for any services furnished to me by them. I authorize any holder of medical information about me released to_____
Any information needed to determine these benefits payable for related services.

_____

Signature of Patient Date