



SIGNATURE ON FILE

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Rodney P. Coe, M.D. for the services furnished me by Rodney P. Coe, M.D. 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 benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form of elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Rodney P. Coe, M.D. accepts the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Center.

SECONDARY

If a Medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms, my signature authorized release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Rodney P. Coe, M.D.

Beneficiary

Medicare Number

Beneficiary Signature

Date