

ADVANCED DERMATOLOGY AND COSMETIC CARE

23861 McBean Pkwy, Suite E-21
Valencia, California 91355

Phone: 661-254-3686

Fax: 661-254-5671

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Bernard Raskin, MD and Associates for any services provided to me by that physician/supplier.

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

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the HCFA-1500 claim form (standard billing form) is completed, my signature authorizes releasing of the information to the insurer or any agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

This form does not replace the Advance Beneficiary Notice (ABN) that I will be asked to sign regarding my decision to receive services based on whether or not they are paid for by Medicare.

Name of Beneficiary

Medicare ID Number

Signature of Beneficiary

Date