

PANAMA CITY PLASTIC SURGERY LLC
RAYMOND A. MOCKLER, M.D. FRCS (C)

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or Insurance benefits be made on my behalf to the provider for any services furnished by the listed provider/supplier. 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 payable for 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, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the provider or carrier 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

Patient's Name

Patient's Signature or Parent/Legal Guardian if Minor

Date