PIEDMONT
INTERNAL
MEDICINE

MEDICARE AUTHORIZATION STATEMENT

I, _____, authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare 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. I understand it is mandatory to notify the health care provider of any other party who may responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

_____ _____

Patient Signature **Date**

Only complete the Medigap Authorization Statement if you have secondary insurance to Medicare that pays for deductibles and co-insurance after Medicare has paid their portion.

MEDIGAP AUTHORIZATION STATEMENT

I, _____, authorize any holder of medical or other information about me to release to Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap 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.

_____ _____

Patient Signature **Date**

Policy Number: _____