



JACKSONVILLE
PAIN CENTER

.....Center for excellent care

Medicare Authorization (For Medicare Patients Only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Hemant Shah for any services furnished to me by the physician and/ or clinic. 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 the benefits payable for related services. I understand my signature request 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 HCFS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Full name

Date

Dr. Hemant Shah

Patients' Signature