Patient Name ____

Medicare Authorization

I am giving Colon Rectal Specialists permission to ask for Medicare payments for my medical care.

I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.

I understand that the Health Care Financing Administration (HCFA) is the government Medicare agency.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Colon Rectal Specialists.

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

Signature: ____ Date: _______________

Sign here if you have Medicare

Medigap Authorization (MEDICARE/ BLUE CROSS)

I am giving Colon Rectal Specialists permission to ask for Medigap payments for my medical care. I understand that my Medigap carrier needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to my Medigap carrier.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Colon Rectal Specialists for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

Signature: ____ Date: _______________

Sign here if you have Medicare AND Blue Cross

Release Statement – ***ALL OTHER INSURANCES***

I hereby authorize Colon Rectal Specialists to release to my insurance company(s) any medical information necessary to process my insurance claims. This may include information related to HIV, alcohol and/or substance abuse, mental health or other medical conditions. I hereby authorize payment of any benefits due under my insurance coverage to go directly to the provider of service. I understand that I am responsible for any amounts not covered by my insurance plan(s).

Signature: ____ Date: _______________

Sign here for all other insurances