HAMBLIN
DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC
928.532.7546

MEDICARE PATIENT REGISTRATION

Please answer the following questions by placing a check in the appropriate column:

Yes	No	
☐	☐	Do you have an insurance policy that replaces Medicare? (i.e.; Atrio, Regency, MedAdvantage)
☐	☐	Are you or your spouse still working?
☐	☐	Are you being treated for this condition at the VA (Veteran's Administration)?
☐	☐	Is this condition covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Are you receiving Medicaid?

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, 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 Medicare insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____________________________________ __________/_________/_________

Signature as name appears on Medicare card Date

If you have a supplemental policy and it is a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

_____________________________________ __________/_________/_________

Signature as name appears on Medicare card Date