ROCKVILLE EYE ASSOCIATES, PC

Patient : _____ Account : _____

ASSIGNMENT OF MEDICARE BENEFITS AUTHORIZATION

I request payment of authorized MEDICARE Benefits be made either to me or on my behalf to ROCKVILLE EYE ASSOCIATES, PC for any services furnished me by the doctors. This authorization applies to all services until it is revoked by me or my representative. I authorize ROCKVILLE EYE ASSOCIATES 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.

_____ _____ _____

Medicare ID # Patient's Signature Date Signed

ASSIGNMENT OF MEDICARE SUPPLEMENTAL INSURANCE BENEFITS AUTHORIZATION

I hereby authorize payment of my Medigap benefits to ROCKVILLE EYE ASSOCIATES, PC for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Medigap Insurer : _____ Medigap Plan ID #:_____

Patient's Signature: _____ Date Signed: _____

ASSIGNMENT OF OTHER INSURANCE BENEFITS AUTHORIZATION

I hereby authorize payment of my Insurance benefits to ROCKVILLE EYE ASSOCIATES, PC for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Primary Insurance: _____ _____

Insurance Company Subscriber's ID Number

Secondary Insurance: _____ _____

Insurance Company Subscriber's ID Number

Patient's Signature: _____ Date Signed: _____