

ONE TIME AUTHORIZATION

Name of Beneficiary

HI Claim Number

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. Thedinger for any services furnished to me by that physician. 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.

X _____
Patient's Signature

Date Signed

MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to Dr. Thedinger for all claims filed in my behalf. This authorization applies to all services until it is revoked by me or my representative.

Beneficiary Signature: **X** _____

Medicare Number: _____

Medigap Insurer: _____

Address: _____

Telephone Number: _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE (TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

Name: _____

Date of Service: _____

(If any answer to questions 1a. through 4. is "Yes," the corresponding section of the "Other Insurance" form must be filled out completely.)

- | | YES | NO |
|---|-------|-------|
| 1. Is the patient a Veteran? | _____ | _____ |
| a. Did the VA refer you here for treatment? | _____ | _____ |
| b. Does the patient have a VA "fee basis ID Card?" | _____ | _____ |
| 2. Do you have a Federal Black Lung card? | _____ | _____ |
| 3. Is this medical condition due to an accident of any kind? | _____ | _____ |
| If "Yes," was it: Work Related <input type="checkbox"/> Auto <input type="checkbox"/> Injured in own home <input type="checkbox"/> Other <input type="checkbox"/> | | |
| 4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member?
(Not retiree coverage) | _____ | _____ |