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 ☐ Auto ☐ Injured in own home ☐ Other ☐		
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)	_____	_____