Grace Dermatology
& Micrographic Surgery

2500 S Main Rd, Lebanon, OR 97355 Phone: (541) 258-SKIN (7546) Fax: (541) 570-1744

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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 medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature as it appears on Medicare Card Date

MEDIGAP

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

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

_____ _____
Signature as it appears on MEDIGAP Card Date

☐ Yes ☐ No Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?

☐ Yes ☐ No Are you covered by any other insurance that Makes Medicare secondary?