# MEDICARE ADVANTAGE/REPLACEMENT SIGNATURE ON FILE

I require that payment of authorized Medicare advantage/replacement benefits be made on my behalf to:

Digestive Disease Consultants
Division of Arizona Digestive Health
3707 N. 7th Street, Suite 305
Phoenix, Arizona 85014

for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA)/Centers for Medicare advantage/replacement (CMMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature (#2 below) requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. The provider or supplier agrees to accept the charge determination of the Medicare advantage/replacement carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare advantage/replacement carrier.

1. PATIENT'S NAME (Please Print): _____

2. PATIENT'S SIGNATURE: _____

3. PATIENT'S MEMBER/ID #: _____