MEDICARE SIGNATURE ON FILE

I require that payment of authorized Medicare 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 and Medicaid Services (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. In Medicare-assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare 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 carrier.

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

2. PATIENT'S SIGNATURE: ____

3. PATIENT'S MEDICARE #: ____