Hartland Foot & Ankle

11518 Highland Rd. Hartland, MI 48353
Phone: (810) 632-7800

MEDICARE PART B AUTHORIZATION AGREEMENT BETWEEN PROVIDER/PHYSICIAN(S) AND PATIENT STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS

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NAME OF BENEFICIARY (CARD HOLDER)

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by this provider. In the case of facility services, this also includes physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

I authorize payment by signature below.

Patient Signature: _____

Provider/Physician Name: **Hartland Foot & Ankle/Scott E. Byron, DPM**

For services furnished by this provider on an outpatient basis, this request/agreement remains in effective until revoked by the beneficiary.

NOTE: This statement of assignment is maintained for each individual patient