Ear, Nose & Throat, P.C.
1965 First Avenue, Opelika, AL 36801
334-705-0012

Medicare Part B
Extended Patient Signature Authorization

TO BE COMPLETED BY PROVIDERS OF SERVICE: Please print or type

Provider Name (If you are a DME supplier, please complete certification at bottom of page) Provider I.D.

East Alabama Ear, Nose & Throat, P.C. 22618, 29120,57904
Providers Address (Street City, State, Zip Code)

1965 First Avenue, Opelika AL 36801
Beneficiary Name **Medicare HI Number** **Applicable Medigap/Group Number**

TO BE COMPLETED BY BENEFICIARY OR AGENT: Directions for Payment of Benefits and Release of Medical Information

Statement for Payment of Benefits: I request that payment of authorized Medicare benefits be made either to me on my behalf to:

Dr. William R. Blythe, Dr. Warren A. Stiles, or Dr. W. Stites Whatley (the supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to be released to Health Care Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Statement For Payment of Medigap Benefits: I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to:

Dr. William R. Blythe, Dr. Warren A. Stiles, or Dr. W. Stites Whatley for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to be released to (name of MEDIGAP insurer):

_____any information needed to determine these benefits or the benefits payable for related services.
Medicare supplemental plan name

X _____ X _____
Signature of Beneficiary or person signing for Beneficiary **Date Signed**

_____
Address of Person Signing for Beneficiary (Street, City, State, Zip Code) **Relationship of Agent to Beneficiary**

_____
Reason Beneficiary is Unable to Sign

Important Information for Physicians

In submitting claims under this procedure, Physicians undertake:
1. To complete and submit properly the appropriate Medicare billing form for all services covered by the request for payment, even those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients. DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF. This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.