



**THE BONE & JOINT INSTITUTE OF JFK MEMORIAL HOSPITAL
JFK Orthopedics**

MEDICARE INFORMATION:

BENEFICIARY NAME

MEDICARE NUMBER

I request that payment of authorized Medicare benefits be made on my behalf to The Bone & Joint Institute of JFK Memorial Hospital and _____ (Physician Name's) for any services furnished to me by the physician and the facility. I authorize any holder of medical information about me to release this information to the Health Care Financing Administration and its agents if needed to determine these benefits or benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician 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 are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE

DATE

NON-MEDICARE INSURANCE ASSIGNMENT:

I hereby authorize and request my insurance company to pay directly to _____ (Physician's Name) and The Bone & Joint Institute of JFK Memorial Hospital the amount(s) due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy I will be responsible to _____ (Physician's Name) and the Facility for the payment of the entire bill.

PATIENT SIGNATURE

DATE

INSURED'S SIGNATURE

DATE