Mineral Surgery Center, LLC

ASSIGNMENT OF MEDICARE AND COMMERCIAL PAYER BENEFITS

PATIENT NAME: _____

MEDICARE or COMMERCIAL PAYER BENEFICIARY #:_____

I request that payment of authorized Medicare and Commercial Payer benefits be made on my behalf to:

Mineral Surgery Center LLC

for any service furnished to me by a physician at that facility. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the facility agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Mineral Surgery Center LLC, for services provided to me at that facility. I authorize any holder of medical information about me to release it to my Medigap insurer,_____(Medigap Insurer's Name), or any information needed to determine these benefits payable for related services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Patient Name	**Chart #**	
Patient Signature	**Date**	**Time**
Signature of Legal Patient Representative: ***(If patient is unable to sign)***	**Date**	**Time**
Witness Signature	**Date**	**Time**