N. Scott Ferguson, OD

479 Main Street
Fryeburg, ME 04037
207-935-3307/Fax207-935-4002

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION

Name of Beneficiary_____Medicare No._____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to N. Scott Ferguson, O.D. For any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claims or electronically submitted claim, my signature authorizes the releasing of the info' to the insurer or agency shown. In Medicare assigned cases, the Optometrist 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, coinsurance, and non-covered services**. Coinsurance and deductibles are based on the charge determination of the Medicare carrier.

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Beneficiary Signature