Marlboro Podiatry Center
223 Taylors Mills Road
Manalapan, NJ 07726

MEDICARE

ONE TIME AUTHORIZATION

_____ _____

Patient Name ***Health Insurance Identification Number***

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO ME OR ON BEHALF TO DR. MARC COHEN FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____ _____

Signature of Patient or Representative ***Date***

ONE TIME AUTHORIZATIONS MUST BE OBTAINED AND RETAINED IN THE PHYSICIAN'S FILES. THE PHYSICIAN SHOULD HAVE THE PATIENT SIGN ANY MEDIUM (CARD, FORM, ETC.) AS LONG AS THE PROPER WORDING IS USED. ONCE THE PHYSICIAN HAS OBTAINED THE PATIENT'S ONE TIME AUTHORIZATION, HE MAY SUBMIT ANY LATER MEDICARE CLAIMS, ON EITHER AN ASSIGNED OR NON-ASSIGNED BASIS, WITHOUT OBTAINING AN ADDITIONAL SIGNATURE OF THE PATIENT.

Name of Beneficiary _____

Health Insurance I.D. Number _____

Medigap Policy Number _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. MARC D. COHEN FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN/SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO _____ (NAME OF MEDIGAP INSURER) ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

Signature of Patient or Representative _____

Date _____

Medigap form