COSMETIC DERMATOLOGY & VEIN CENTERS
Scott Friedman, D.O.

INSURANCE VERIFICATION FORM

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ALL OTHER INSURANCE

Patient's or Authorized Person's Signature:

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits either to myself or the physician who accepts assignment.

_____ _____
Signature of the Insured or Authorized Person Date

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MEDICARE AND SUPPLEMENT INSURANCE

This form is required to keep your signature on file, authorizing us to file claims to Medicare for you and to release information that the payer requires for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Health Care Financing Administration (or its intermediaries or carriers) any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits only apply.

_____ _____
Signature as it appears on Medicare Card Date

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If you have a supplement policy and it is a Medigap policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap carrier any information needed to determine these benefits for the benefits payable for related services.

_____ _____
Signature as it appears on Medicare Card Date