SURESH G. KAMATH MD

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Kamath for services furnished me by Dr. Kamath. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA – 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing information to the insurer or agency shown.

Doctor Kamath accepts the charge determination of the Medicare carrier, blue shield of Western New York, or applicable DMERC, as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Medicare/Wellcare Senior/Senior Advantage Signature   Date

If a Medigap policy or other health insurance is indicated in item 9 of the HCFA – 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Doctor Kamath.

Medigap/Secondary Insurance Signature   Date

I hereby authorize payment of my medical and surgical insurance benefits to Dr. Kamath. I understand that I am financially responsible for any charges, whether or not paid by said insurance. If co-payment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Dr. Kamath. I authorize Dr. Kamath to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Other Insurance Signature   Date