

BEACON HEALTHCARE ASSOCIATES

41 Oakland Road, Suite 100
Asheville, NC 28801

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PATIENT REASSIGNMENT OF BENEFITS FORM

Please read and sign the following

MEDICARE PATIENT:

I request that payment of authorized Medicare Benefits be made either to me on my behalf or to **Beacon Healthcare Associates (David A. Clements, MD, PLLC)** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or 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 Item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician 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, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

- **SIGNATURE** _____
- **DATE** _____
- **Medicare ID #** _____
- **Print Name** _____