Palm Harbor Dermatology
CANCER AND LASER SURGERY CENTER

Medicare Patient Registration

Name: _____ Jr Sr
First Middle Last

Date of Birth: _____
Month / Day / Year

Have you recently joined a Medicare HMO? **YES NO**

If yes, identify: _____

Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job? **YES NO**

Are you covered by a HMO/PPO which makes Medicare secondary? **YES NO**

Is this illness covered by the VA (Veteran's Administration)? **YES NO**

Is this illness due to an automobile accident? **YES NO**

Is this illness due to an injury at work? **YES NO**

Are you receiving Medicaid? **YES NO**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it 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 Center for Medicare and Medicaid Services, or its intermediaries or carrier, 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 of benefits apply.

_____ ____/____/____
Signature as it appears on Medicare Card Date

If you have a supplemental 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 or the benefits payable for related services.

_____ ____/____/____
Signature as it appears on Medigap Card Date