

Cohen Medical Associates

Lifetime Authorization			Chart Number:		
Indicate plan (<i>circle all that apply</i>): Medicare Cigna United Other (<i>specify</i>):					
Patient name (<i>last, first MI</i>):					
Home address:	<i>street</i>			<i>apartment</i>	
	<i>city</i>		<i>state</i>		<i>zip</i>
Social Security Number: - -		Sex (circle): M F		Date of Birth: / /	
Medicare: "I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance."					
Signature:				Date: / /	
Printed name:			HIC (Medicare) Number: - - -		
If signed by anyone other than the patient, indicate relation to patient:					
If signed by anyone other than the patient, indicate reason:					
Medigap: "I request that payment of authorized Medigap benefits be made on my behalf to Cohen Medical Associates for services furnished me by Robert Cohen D.O., Douglas Colman, D.O., Lee Greene, M.D. and JoAnn Yi, M.D.. I authorize any holder of medical information about me to release to _____ (<i>insurance company</i>) any information needed to determine these benefits or the benefits payable for related services."					
Signature of Beneficiary:				Date: / /	
Beneficiary's printed name:					
HIC (Medicare) Number: - - -			Medigap Number:		
If signed by anyone other than the patient, indicate relation to patient:					
If signed by anyone other than the patient, indicate reason:					
Insurance: "I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me."					
Signature:				Date: / /	
Printed name:			Contract/Policy/ID number:		
If signed by anyone other than the patient, indicate relation to patient:					
If signed by anyone other than the patient, indicate reason:					