Name: _____

Medicare #: _____

I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to Lodi Physical Therapy and the PUMP Institute for any services furnished me by that supplier.

I authorize any holder of medical information that pertains to me be released to Health Care Financing Administration, and it's agents, any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and further authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, 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 and non-covered services. Coinsurance and deductible are based upon the charge determination of Medicare carrier.

Signature: _____

Date: _____

MEDICARE LIMITS: **$1,980 per calendar year (January-December) for out-patient physical therapy (includes speech therapy).**

Patient Initials: _____

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES, OR HAVE YOU HAD HOME HEALTH SERVICES IN THE PAST 3 MONTHS?

YES_____ **NO_____**

_____
Office Clerk Initials