# SIGNATURE ON FILE

☐ **MEDICARE**

I request that payment of authorized Medicare benefits be made on my behalf to James M. Maisel, M.D. for the services furnished me by James M. Maisel, M.D. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable to related service.

I understand my signature requests that payment be made and authorizes 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 the information to the insurer or agency shown.

James M. Maisel, M.D. accepts the charge determination of the Medicare carrier as the full charge and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Center.

☐ **SECONDARY**

If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 claim 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 either to me or on my behalf to James M. Maisel, M.D.

_____ _____

Beneficiary Medicare Number

_____ _____

Beneficiary Signature Date



**James M. Maisel, M.D. • Rodney P. Coe, M.D. • Sabah A. Shah, M.D.**

400 South Oyster Bay Road, Suite 305
Hicksville, NY 11801-3516
Tel (516) 939-6100
Fax (516) 939-2510

*Vitreoretinal and Laser Surgery*
*www.rgony.com*

1455 Veterans Memorial Highway
Hauppauge, NY 11749
Tel (631) 273-1818
Fax (516) 939-2510