MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Charles G. Godoshian, M.D., for any services furnished to be by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Dr. Charles Godoshian for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

Patient Name:_____

Patient Signature:_____ Date:_____