STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT

Name of Beneficiary _____ **Health Insurance Claim Number** _____

General Rules

You must pay the annual Medicare Part B deductible toward any qualified health care before Medicare will pay for any services. After you meet your deductible, Medicare will pay 80 percent of the doctor's "approved fee." You will pay 20 percent as a co-payment, plus any non-covered fees.

Our office will bill Medicare and accept payment directly from them if the services qualify for coverage (see exceptions below). You are responsible for paying for any non-covered services at the time of your office visit.

Special Exceptions

1. Medicare does not cover eyeglasses or contact lenses unless we reach a diagnosis of "aphakia" or "pseudophakia."
2. Medicare does not cover the refraction part of the eye exam
3. Medicare does not cover any services unless we make a medical diagnosis. If your only diagnosis is myopia, hypermetropia, astigmatism, or presbyopia, Medicare will not pay for any services.
4. Medicare may deny benefits if it feels you are receiving examinations too frequently or receiving exams by more than one doctor for the same illness.

I have read and understand the above information. I agree to pay for services and materials which I order, but that Medicare does not cover.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Basin Vision Center, P.C. for any services furnished me by this provider. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Centers for Medicare & Medicaid Services or its agents.

My signature on this form will serve as a **"SIGNATURE ON FILE"** for processing claims forms.

Patient's Signature _____

Date _____

02/07/2019