Coastal Cardiovascular Consultants, PA

Practice Limited to Cardiovascular Disease

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MEDICARE AUTHORIZATION

NAME OF BENEFICIARY _____

DATE OF BIRTH: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Cardiovascular Consultants, P.A. for any services furnished me by the providers of that practice. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature of beneficiary or authorized representative Date

MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Coastal Cardiovascular Consultants, P.A. for any services furnished me by the providers of that practice. I authorize any holder of medical information about me to release to _____ any
(name of Medigap insurer)
information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature of beneficiary or authorized representative Date

MEDICARE ONLY INSURANCE/MEDICAID WAIVER

I understand that Coastal Cardiovascular Consultants, P.A. is a **non-participating** provider with the New Jersey **Medicaid** program. I am responsible for payment of any Medicare deductible and/or co-insurance amounts due for services rendered to me by the practice.

_____ _____
Signature of beneficiary or authorized representative Date