



40 Stirling Road ■ Watchung, New Jersey 07069 ■ 908-769-8000

MEDICARE AUTHORIZATION

Patient Name \_\_\_\_\_

Medicare ID # \_\_\_\_\_

I request that payment of authorized Medicare benefits be made on my behalf to Surgicare of Central Jersey, Inc. for any services furnished to me by that supplier. I authorize any holder of the medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

MEDIGAP AUTHORIZATION

Name of insurance \_\_\_\_\_ ID# \_\_\_\_\_

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Surgicare of Central Jersey, Inc. I authorize any holder of Medicare information about me to release to \_\_\_\_\_ (name of insurance company) any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date