

GREENBRIER PHYSICIANS, INC.

GREENBRIER VALLEY MEDICAL ARTS BUILDING
200 MAPLEWOOD AVENUE AT FAIRLEA
RONCEVERTE, WV 24970-1398
TELEPHONE 304-647-5115
OR 1-800-677-5161

Name of Patient

**Statement to permit payment of Medicare Benefits
to Provider, Physicians and Patients**

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made either to me or **GREENBRIER PHYSICIANS, INC.** on any bills for services furnished me by **GREENBRIER PHYSICIANS, INC.**

Signature of Patient

Date Signed

Health Insurance Claim Number

FOR OUT-PATIENT OR IN-PATIENT SERVICES, I REQUEST THAT THIS AUTHORIZATION APPLY TO THE PERIOD
I N D E F I N I T E (LIFETIME).

COMMERCIAL INSURANCE, MEDICAID, UMWA, WORKMEN'S COMPENSATION

I authorize payment of medical benefits to undersigned physician or supplier (**GREENBRIER PHYSICIANS, INC.**) for service described on AMA computerized billing form. I authorize any holder of medical or other information about me to release to my insurance carrier any information needed for this or a related claim.

FOR OUT-PATIENT OR IN-PATIENT SERVICES, I REQUEST THAT THIS AUTHORIZATION APPLY TO THE PERIOD
I N D E F I N I T E (LIFETIME).

SIGNATURE ON PERMANENT FILE.

Signed _____ Date _____
(patient or authorized person)