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 **INDEFINITE (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 **INDEFINITE (LIFETIME).**

SIGNATURE ON PERMANENT FILE.

Signed _____ Date _____
(patient or authorized person)

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