MEDICARE AUTHORIZATION AND ASSIGNMENT OF BENEFITS
Dermatology Associates of York, Inc.

Patient Name: Primary Insurance# Group#
☐ Check here if Medicare is your primary insurance
☐ Check here if you have a Medicare Advantage Plan, please list name of
Medicare Advantage Plan:
I am aware that Dermatology Associates does not participate with my insurance plan.
☐ If Medicare is not your primary insurance, please list name of primary insurance carrier:

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized Medicare benefits be made either to me, or on my behalf, for any service furnished to me by Dermatology Associates of York, Inc. I understand that I am responsible for any deductibles, copayment amounts, or any amounts not covered by Medicare.

/
PATIENT IS UNABLE TO SIGN BECAUSE:
RELATIONSHIP TO PATIENT

RELEASE OF INFO AND ASSIGNMENT OF BENEFITS (FOR SECONDARY INSURANCE}

Policyholder's Name D.O.B.
Your SECONDARY Insurance Company's Name
Policyholder's ID# Group Plan #

I authorize any holder of Medicare information about me to release to and information needed to determine these benefits payable for related services. I request that payment for authorized Medigap benefits be made either to me or on my behalf to Dermatology Associates of York, Inc. for any services furnished to me by Dermatology Associates of York, Inc.