MGM
MEDICAL ASSOCIATES LTD. S.C.

NON-HMO PATIENTS ONLY

IRS# 06-1654745

TO BE COMPLETED BY MEDICARE PATIENTS ONLY:

PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

Name of Beneficiary (Patient) _____ Health Insurance Claim Number _____

Part A Effective Date: _____ Part B Effective Date: _____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to MGM Medical Associates, Limited, S.C. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Patient Signature _____ Date _____

TO BE COMPLETED BY PPO, EPO, COMMERCIAL MEDICARE PATIENTS ONLY:

ASSIGNMENT OF INSURANCE BENEFITS

Patient Name _____ Sex _____

Insurance Company Name _____ Phone No. _____

Insurance Company Address _____
(City) (State) (Zip Code)

Subscriber _____ Relationship _____

Certificate/Social Security No. _____ Group No. _____

Employer Name _____ Employer Phone No. _____

Indicate others covered by this insurance _____

I hereby authorize and request the insurance company, or agent thereof, to pay directly to MGM Medical Associates, Ltd. for Medical or Surgical services rendered to me or a member of my family.

This signature will also serve as authorization to release medical information necessary to satisfy payment.

Signature of Patient or Authorized Person _____ Date _____

OTHER INSURANCE COVERAGE FOR PATIENT:

Name _____ Address _____
(Insurance Company)

_____
(City) (State) (Zip Code)

Subscriber _____ Relationship _____

Subscriber's Spouse (If other than patient) _____

Patient Name _____ Sex _____

Insurance Company Name _____ Phone No. _____

Insurance Company Address _____
(City) (State) (Zip Code)

Certificate/Social Security No. _____ Group No. _____

Employer Name _____ Employer Phone No. _____