Nuclear Medicine Associates
1950 Court Street
Redding, CA 96001
(530) 225-8008

_____ _____
(Name of Patient) (Medicare Number)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Nuclear Medicine Associates for any services furnished me by that physician or 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 payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown, In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____
(Signature) (Date)