Cataract, Glaucoma & Retina
CONSULTANTS OF EAST TEXAS
Medical Arts Surgery Center | Benchmark Optical

ASSIGNMENT OF MEDICAL BENEFITS

PATIENT'S NAME: ______________________ **DATE:** ______________

Medicare Insurance

I request that payment of authorized Medicare benefits be made on my behalf to ***Cataract, Glaucoma & Retina Consultants of East Texas, Medical Arts Surgery Center, or Benchmark Optical*** or any physician of that group, for any services furnished to me by my physician of the group. 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 for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and ***I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay and/or non-covered services.***

Medicare #: ______________

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Signature: ______________________ **Date:** ____________

Witness: ______________________ **Date:** ____________

Any Other Insurance

I request that the payment of authorized benefits of my insurance benefits be made either by me or on my behalf to ***Cataract, Glaucoma & Retina Consultants of East Texas, Medical Arts Surgery Center, or Benchmark Optical*** or any physician of that group, for service provided to me or any information needed to determine the benefits payable for related service to release it to my insurer. ***I know that I am responsible for any deductible, co-pay, co-insurance, and/or any non-covered services***.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Signature: ______________________ **Date:** ____________

Witness: ______________________ **Date:** ____________

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