

**MID AMERICA HEART, P.C.**

310 N. Seven Hills Road, Suite 150; O'Fallon, IL 62269

4550 Memorial Drive, Suite 320; Belleville, IL 62226

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to Mid America Heart, P.C., for any services furnished me by their physicians. I authorize any holder of medical information about me to release to CMS and its' agents any information needed to determine these benefits or the benefits payable for 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" is indicated in item 9 the of CMS 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer of the agency shown. In Medicare assignment claims, 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, co-insurance, and non-covered services.

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**Beneficiary Signature**

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**Date**

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**Print Name**