Vision Care 4Life Insurance Signature On File

____ ____________________________

Beneficiary's Name (print) **Medicare Identification No.**

1. **MEDICARE**

   I request that payment of authorized Medicare benefits be made on my behalf to **Vision Care 4Life**. 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 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 is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

   Vision Care 4Life accepts 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 the deductible are based upon the charge determination of the Medicare carrier.

____ __________________

Signature **Date**

2. **MEDIGAP**

   If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to **Vision Care 4Life**.

____ __________________

Signature **Date**

3. **OTHER INSURANCE**

   I hereby authorize payment of my medical and surgical insurance benefits to **Vision Care 4Life**. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Vision Care 4Life**. I authorize **Vision Care 4Life** to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

____ __________________

Signature **Date**