

**ASSIGNMENT OF BENEFITS**  
**ALL INSURANCE EXCEPT MEDICARE**

I authorize my insurance company to pay benefits on my behalf directly to Germain Dermatology Associates. I authorize Germain Dermatology Associates to provide to my insurance company any information necessary to process claims for services rendered to me.

\_\_\_\_\_  
**Signature of Patient/Guardian**

\_\_\_\_\_  
**Date**

**MEDICARE**

I authorize medical or other information about me to be released to the Social Security Administrations and Health Care Financing Administration or its intermediaries or carrier needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**Are you covered by any other insurance that makes Medicare secondary? Y / N**

**If Medicare is your secondary insurance, please circle the type of coverage you have:**

- |   |                                   |
|---|-----------------------------------|
| 1. Working Aged/Spouse Group Plan             | 6. Veteran's Admin                |
| 2. ESRD                                       | 7. Disabled                       |
| 3. No Fault/Auto Primary                      | 8. Beneficiary Under age 65       |
| 4. Worker's Comp                              | 9. Other Liability Ins is Primary |
| 5. Public Health Service/<br>Other Fed Agency | 10. Black Lung                    |

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient/Guardian**

\_\_\_\_\_  
**Date**

**MEDIGAP**

If you have a supplemental policy and it is a MEDIGAP policy to which you're Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
**Signature of Patient/Guardian**

\_\_\_\_\_  
**Date**