PHYSICAL THERAPY SPECIALTIES

3908 VALLEY AVENUE
SUITE B
PLEASANTON
CALIFORNIA 94566
TEL 925-417-8005

Medicare Authorization Statement

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Physical Therapy Specialties for any services furnished to me by that provider. 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 noncovered services and supplies. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

I understand that to continue physical therapy, Medicare requires that I see my referring physician every 30 days.

Patient Name (*Please Print*): _____

Patient Signature: _____

Date: _____