MEDICARE AUTHORIZATION OF BENEFITS

I, _____ request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Marc L. Frost, M.D. (Academy Dermatology) for service furnished me by the above named physician. 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 for related services.

_____

(Signature)

SUPPLEMENTAL INSURANCE AUTHORIZATION OF BENEFITS

I, _____ request that payment of authorized supplemental benefits be made on my behalf to Marc L. Frost, M.D. (Academy Dermatology) for any services furnished me by the above named physician. I authorize any holder of medical information about me to release to my supplemental insurance company any information needed to determine these benefits or the benefits payable for related services.

_____

(Signature)

(MDCRAUTH)
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