PAUL S. SCHWARTZ, D.P.M.
SURGERY, DISEASES AND INJURIES OF THE FOOT AND ANKLE, SPORTS MEDICINE

Diplomate, American Board of Foot Surgeons
Fellow, American College of Podiatric Surgery

112 La Casa Via #130, Walnut Creek, CA 94598 • PHONE (925) 943-6203 • FAX (925) 943-1736

MEDICARE PATIENTS ONLY

LIFETIME BENEFICIARY AUTHORIZATION

(NAME OF BENEFICIARY) _____ (HIC NUMBER) _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Paul S. Schwartz, D.P.M. for any services furnished me by that physician or supplier. 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 authorize 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 Medicare assigned cases, the physician or supplier agrees to accept charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

It is my understanding that Medicare does not cover all office procedures and that it will be my responsibility to take care of the non-covered billings.

BENEFICIARY SIGNATURE _____ DATE _____