KANSAS FOOT CARE
ASSOCIATES, P. A.
DISEASES & SURGERY OF THE FOOT

ONE TIME AUTHORIZATION

_____ _____
Patient Name Medicare Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kansas Foot Care Associates, P.A. for any services furnished to me by any of their representatives. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Number _____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Kansas Foot Care Associates, P.A. for any services furnished to me by any of their representatives. I authorize any holder of medical information about me to be release to:

_____
Secondary Insurance Company

Any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient's Signature Date Signed