Diagnostic Cardiology of Houston, P. A.
7777 Southwest Freeway, Suite 420
Houston, Texas 77074
713-776-9500

MEDICARE CLAIMS

Name of Beneficiary: ____

HIC Number: ____

I request that payment of authorized Medicare benefits be made on my behalf to Diagnostic Cardiology of Houston, P. A. for any services furnished me by Diagnostic Cardiology of Houston, P. A. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS)
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 item 9 of CMS 1500 claim form is completed, my signature authorized 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, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: ____

Date: ____