cape radiology group

ASSIGNMENT OF BENEFITS

I request the payment of Medicare and/or other insurance benefits made on my behalf to Cape Radiology Group for any services provided to me by Cape Radiology Group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or to any other entity, any information necessary to determine these benefits for related services. In the event these or any other services provided by Cape Radiology Group are not medically necessary or not covered by Medicare, Medicaid, or other insurance, I understand I am financially responsible for these charges.

_____ _____

Patient/Guardian Signature* Patient Medicare/Insurance Number

_____ _____

Name (Print) Date of Birth

_____ _____

Address Today's Date

_____

City, State, Zip Code

_____

Phone Number

*If patient is under the age of eighteen the person financially responsible for them must sign this form.