PREMIER HEART GROUP

LESLIE E. MEZEI, MD, FACC

MEDICARE SIGNATURE ON FILE CARD
(For Medicare Patients Only)

Your Name: (Please Print)_____
(Last Name) (First Name)

Your Medicare Number:_____ MALE / FEMALE
(Circle One)

I request that payment of authorized Medicare benefits be made to either me or on my behalf to St. John's Cardiovascular Associates (D.B.A.: Premier Heart Group) for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits for related services.

_____
(Patient's Signature)

MEDIGAP/SUPPLEMENTAL INSURANCE SIGNATURE ON FILE CARD

Your Name: (Please Print)_____
(Last Name) (First Name)

Medicare Number: _____

Medigap or Supplemental Policy Number:_____

I request payment of authorized Medigap or Supplemental Insurance benefits to be made by me or on my behalf to St. John's Cardiovascular Associates (D.B.A.: Premier Heart Group) for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to be released to _____ any information to determine that these benefit or benefits payable for related
(Name of Insurance Company)
services.

_____
(Patient's Signature)

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