## Medicare Signature on File

**Name of Beneficiary** **Medicare #**

I request that payment of authorized Medicare benefits be made on my behalf to Williamsburg Plastic Surgery for any services furnished to me by them. 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 or the benefits payable for related services.

**Signature** **Date**

## Supplemental Signature on File

**Name of Beneficiary** **Supplemental Policy #**

I request that payment of authorized Medicare Supplemental benefits be made on my behalf to Williamsburg Plastic Surgery for any services furnished to me by them. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

**Signature** **Date**