Ear, Nose, Throat and Allergy Center
Mark Welch, D.O., F.A.O.C.O.

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made payable on my behalf to the providers listed below for any services furnished to me by the listed providers. I authorize benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA -1500 for my signature authorizes releasing of the information to the insurer or agency shown.

_____ _____

Patient's Signature Date

INSURANCE SIGNATURE ON FILE

I request that payment of authorized insurance benefits be made payable on my behalf or the insurer's behalf to the providers listed below for any services furnished by the listed providers. I authorize providers of medical services to release any medical and/or claim information about me or the insured necessary to secure the payments.

_____ _____

Patient's Signature Date

Mark Welch, D.O., F.A.O.C.O.
1715 North Lynn Riggs Blvd.
Claremore, OK 74017

A PHOTOCOPY OF THIS DOCUMENT IS TO BE CONSIDERD AS VALID AS AN ORIGINAL.