Scott Darling D.O., P.C.
Skin, Vein & Skin Surgery Center

Assignment of Benefits

All Insurances except Medicare

I authorize Scott Darling D.O., P.C.to provide information to my insurance company that is necessary to process claims for services rendered to me. I authorize my insurance company to pay benefits on my behalf directly to Scott Darling D.O., P.C.

Signature ____ **Date** ____________________

Medicare Lifetime Consent (OMB-0222)

I request that payment of authorized Medicare benefits be made on my behalf to Scott Darling D.O., P.C. for any services rendered to me by Dr. Scott Darling. 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 payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature ____ **Date** ____________________

Medigap/Medicare Supplement (Secondary Insurance)

If you have a supplemental policy and it is a Medigap/Medicare Supplement policy or other policy to which your Medicare carrier automatically “crosses over”, we are required to keep a separate signature on file. I request authorized Medigap/Medicare Supplement benefits be made on my behalf for any services rendered to me. I authorize any holder of medical information to release any information needed to my Medigap/Medicare Supplement carrier to determine these benefits or the benefits payable for related services.

Signature ____ **Date** ____________________

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? □Yes □No

Are you covered by any other insurance that makes Medicare secondary? □Yes □No