



ALABAMA ORTHOPAEDIC CLINIC, P.C.

Medicare Part B

Extended Patient Signature Authorization

TO BE COMPLETED BY PROVIDERS OF SERVICE - Please PRINT or TYPE

Form with fields for Provider's Name (ALABAMA ORTHOPAEDIC CLINIC, P.C.), Provider's I.D. Code, Provider's Address (3610 Springhill Memorial Drive North, Mobile, Alabama 36608), Beneficiary's Name, Medicare HI Number, and Applicable MEDIGAP Group Number.

TO BE COMPLETED BY BENEFICIARY OR AGENT - Directions For Payment Of Benefits And Release of Medical Information

Form with two sections: STATEMENT FOR PAYMENT OF MEDICARE BENEFITS and STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS. Includes signature and date lines for the beneficiary or agent.

Form with fields for Address of Person Signing For Beneficiary (Street, City, State, ZIP Code) and Relationship Of Agent To Beneficiary.

Form with field for Reason Beneficiary Is Unable To Sign.

IMPORTANT INFORMATION FOR PHYSICIANS

Form containing instructions for physicians regarding Medicare billing, claim submission, and cancellation of authorization.

IMPORTANT INFORMATION FOR SUPPLIERS

Form containing instructions for suppliers regarding signature authorization and overpayment responsibility.

DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

Form containing a note and a statement for durable medical equipment suppliers, including a signature and date line.