MEDICARE

PART B

EXTENDED PATIENT SIGNATURE AUTHORIZATION

To Be Completed by Providers of Service **Please** print or type

Provider's Name*	Provider's I.D. Code
Surgery Center South	**55049**

Provider's Address (Street, City, State, Zip)

2800 Ross Clark Circle, Suite 3 Dothan, AL 36301-2040

Beneficiary's Name	Health Insurance Number

Payments for Services rendered is to be made as follows

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Anesthesia Group and Surgery Center South (the Supplier) for any services or items furnished me by that physician or supplier. 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."

X _____ _____

Signature of Beneficiary or person signing for Beneficiary — Date signed

Address of person signing for Beneficiary (Street, City, State, Zip) — Relationship

Reason Beneficiary is unable to sign

In submitting claims under this procedure. PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment - **even those in which the physician has not accepted assignment.**
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients. **"DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF.** "This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

In submitting claims under this procedure. SUPPLIERS agree to:

1. Only use the extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement:
   "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED"

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.

***FOR SUPPLIERS OF DURABLE MEDICARE EQUIPMENT ONLY:**

"This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of or the end of need for the rental of equipment, or the death or instituionalization of the Beneficary."

_____ _____

Signature of Supplier — Date Signed

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East, Birmingham, Alabama 35298

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