

Urology Associates of Kingsport, P. C.

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Urology Associates of Kingsport, P.C. for any services furnished to me by that physician/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.

SIGNATURE

DATE

PRINT NAME

MEDICARE NUMBER

MEDIGAP

I request that payment of authorized Medigap benefits be made on my behalf to Urology Associates of Kingsport, P. C. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits.

SIGNATURE

DATE

PRINT NAME

MEDIGAP POLICY