

Eye Clinic of Meridian, PLLC

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Diplomate, American Board of Ophthalmology

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Eric J. Johnson, II, O.D.
Certified Therapeutic Optometrist

Thi H. Bui, O.D.
Certified Therapeutic Optometrist

Eye Clinic of Meridian • Butler Eye Center • Livingston Eye Center • Meridian Eyecare

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER OR PHYSICIAN

PATIENT NAME _____

I request that payment of authorized Medicare benefits be made on my behalf to THE EYE CLINIC'S providers for services furnished me by either physician (DON E. MARASCALCO, M.D., J. LAWRENCE MASON, JR., M.D., ERIC J. JOHNSON, II, O.D., THI H. BUI, O.D.). I authorized 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 SIGNED _____

STATEMENT TO PERMIT PAYMENT OF MEDICAID, MEDIGAP, OR SUPPLEMENT INSURANCE BENEFITS TO PROVIDER OR PHYSICIAN

PATIENT NAME _____

I request that payment of authorized Medicaid, Medigap, or any supplemental insurance benefits be made on my behalf to THE EYE CLINIC'S providers for services furnished me by either physician (DON E. MARASCALCO, M.D., J. LAWRENCE MASON, JR., M.D., ERIC J. JOHNSON, II, O.D., THI H. BUI, O.D.). I authorize THE EYE CLINIC'S providers to release Medicaid, Medigap or any other insurance carrier, any medical or other information about me needed for payment of medical insurance benefits. I request that payment of benefits be made to myself, or to the party accepting assignment.

I certify that the information given by me in applying for payment is correct.

SIGNATURE _____

DATE SIGNATURE _____