LENITA HANSON MD PA dba HANSON DIABETES CENTER
21216 Olean Blvd., Ste 6, Port Charlotte, Fl 33952
Tel: 941-624-4800 Fax: 941-206-0048
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LIFETIME MEDICARE B AUTHORIZATION AND AGREEMENT
If you are covered by Medicare, Please complete

For services beginning_____, I authorize any holder of medical of other information about me to release to the social security administration and Health care Financing Administration or its intermediaries or carriers, or to other billing agents of Lenita Hanson, M.D., P.A. any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payments of medical insurance benefits, either to myself or to the party who accepts assignments.

Medicare number: _____

Patient Name (Printed) _____

Relationship to Insured _____

Signature of Insured/Parent/Guardian _____

Date _____

MEDIGAP INSURANCE
(Supplement)

I request that payment of authorized Medigap benefits be made on my behalf Lenita Hanson, M.D., P.A. which includes any information needed to determine these benefits or the benefits for relating services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross- over automatically.

Insurance Policy name: _____

Insurance Policy Number:_____

Relationship to Insured _____

Signature of Insured/Parent/Guardian _____

Date _____