NEW YORK GASTROENTEROLOGY ASSOCIATES

Assignment of Medicare Benefits

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Name of Patient **Medicare Identification Number**

I request that payment of authorized Medicare benefits be made on my behalf to NYGA physicians for any services provided to me by these physicians. 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 payable for related services.

I also understand that I will be financially responsible for payment of those medical services provided by NYGA physicians which are deemed medically necessary, but which are not reasonable or necessary per Medicare. If I undergo a screening Colonoscopy, I understand that I will be responsible for my annual deductible and co-insurance if a diagnosis is found.

_____

Signature of Patient

_____

Date

I have informed NYGA physicians that I am not covered by Medicare and that I will not submit any medical insurance claims to Medicare for the services that he has provided me.

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Signature of Patient

_____

Date