**Boston Osteopathic Health**

**134 Rumford Ave. Suite 208**

**Newton, Ma 02466**

**617-431-4451**

1. **Medicare Authorization**

Beneficiary Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HIC# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that payment of authorized Medicare benefits be made to me or on my behalf to Boston Osteopathic Health for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits of the benefits payable for related services.

Beneficiary Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Medigap Authorization**

Beneficiary Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HIC# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that payment of authorized Medigap benefits be made to me or on my behalf of Boston Osteopathic Health for any services furnished me by this provider. I authorize any holder of medical information about me to my insurance company any information needed to determine these benefits or benefits payable for related services.

Beneficiary Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Authorization of Payment**

I authorize payment of medical benefits by my insurance company for all covered services provided by Boston Osteopathic Health.

Signature of Insured or Authorized Person’s Signature

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Authorization to Release Information**

I authorize the release of any medical information or other information necessary to Boston Osteopathic Health.

Signature of Insured or Authorized Person’s Signature

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_