218 West D Street, McCook, NE 69001
308-345-5800 800-759-1244
www.lecvisionsource.com

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Stamm or Dr. Gray for any services furnished me by that physician. 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.

Patient Signature:____

Date:____

Insurance

Patient:____________________________________ Date________________

- By SIGNING this, you agree to be financially responsible for any balance not paid by your insurance.
- Lifetime Eyecare does not guarantee amounts quoted by insurance companies for benefits.
- I authorize Lifetime Eyecare to furnish my insurance company all the information they may request concerning my treatment.
- I request payment of authorized insurance benefits be made to Lifetime Eyecare.

Financially Responsible Name:____

Signature:__________________________________ Date:________________