

TRI-COUNTY SURGICAL ASSOCIATES, P.A.  
9239 Medical Plaza Drive  
Charleston, South Carolina 29406

ASSIGNMENT OF MEDICARE BENEFITS

NAME OF PATIENT OR BENEFICIARY: \_\_\_\_\_

MEDICARE NUMBER: \_\_\_\_\_

AUTHORIZATION STATEMENT TO ASSIGN MEDICARE BENEFITS

I hereby request that payment of authorized **Medicare** benefits be made on my behalf to Tri-County Surgical Associates, P.A. for any services provided to me by the physicians of Tri-County Surgical Associates, P.A. I also authorize the release of any necessary medical information required for determination of payment.

Signature of Patient or Representative: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*\*\*\* **IF MEDICARE AUTOMATICALLY SENDS THE BALANCE TO A SECONDARY INSURANCE COMPANY YOU MUST SIGN BELOW** (some examples of secondary insurance companies include Blue Cross/Blue Shield, AARP, Pioneer Life)\*\*\*\*\*

AUTHORIZATION STATEMENT TO ASSIGN MEDIGAP BENEFITS

I hereby request that payment of authorized **MEDIGAP** benefits made on my behalf to Tri-County Surgical Associates, P.A., for any services provided to me by the any of the Physicians of Tri-County Surgical Associates, P.A. I also authorize the release of any necessary medical information required for determination of payment.

Signature of Patient or Representative: \_\_\_\_\_

Date: \_\_\_\_\_