MERCED ORTHOPAEDIC MEDICAL GROUP, INC.

SABLAN ORTHOPEDICS, INC.

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MEDICARE AUTHORIZATION STATEMENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to either Merced Orthopedic Medical Group, Inc. or Sablan Orthopedics, Inc. for any services furnished to me by that physician or supplier. 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 to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and noncovered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Merced Orthopaedic Medical Group, Inc. or Sablan Orthopedics, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ _____ (Medigap Insurer) any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature Date

_____ _____

Printed Name Medicare Number