

Medicare Part B Authorization & Acknowledgement Form

Statement to Permit Assignment of Medicare Benefits

I understand that I am giving **H-E-B Pharmacy** permission to ask for Medicare payments for my medical care, including supplies and equipment.

I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.

I understand that the Centers for Medicare & Medicaid Services (CMS) is the Government's Medicare agency.

I understand that a photocopy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or co-insurance amounts.

Therefore, I ask that payment of authorized Medicare benefits be made to either me or on my behalf to **H-E-B Pharmacy** for any services or items furnished to me by **H-E-B Pharmacy**. I authorize any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits for related services.

Name: _____ **HICN:** _____

Signature: _____ **Date:** _____
(Beneficiary's Signature)

Patient Acknowledgements

I have received written notice of my rights and responsibilities as a Patient/Caregiver.

I have received written instructions for filing a complaint or grievance.

I have received a copy of the Medicare Supplier Standards.

I have received contact information for H-E-B Pharmacy.

Signed: _____ **Date:** _____
(Beneficiary's Signature)

Policy Name : _____ Policy Number : _____

I understand that I am giving **H-E-B Pharmacy** permission to ask for Medigap payments for my medical care.

I understand that the above named Medigap Insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to the above named insurer.

I ask that payment of authorized Medigap benefits be made either to me or on my behalf to **H-E-B Pharmacy**, for any services or items furnished to me by **H-E-B Pharmacy**. I authorize any holder of medical information about me to release such information to the above named Medigap Insurer as needed to determine these benefits or the benefits payable for related services.

Signature: _____
(Beneficiary's Signature)

Date: _____