ARUNA BAKHRU, M.D.
KANDR BUILDING
22 IBM ROAD, SUITE 104B
Poughkeepsie, New York 12601
Telephone: (845) 463-1044 FAX: (845) 463-1043

# MEDICARE AUTHORIZATION PAYMENT RELEASE

Name of Beneficiary _____

Health Insurance Claim Number _____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Aruna Bakhru, M.D. for services rendered to me by the 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 payable for related services.

My signature on this form will serve as "Signature On File" for Medicare and any supplemental insurance for billing purposes only. This document will remain in force unless revoked in writing by me.

I, the undersigned, agree to pay Aruna Bakhru, M.D. the remaining amount of money which is not paid for by Medicare and any supplemental insurance for the medical services rendered by Dr. Bakhru.

Patient's Signature: _____

Date Signed: _____

Physician's Signature: _____ Date: _____