



Allied Orthotics & Prosthetics
813 Eastgate Drive
Mount Laurel, NJ 08054
856-273-6400
Fax 856-273-0506

MEDICARE SIGNATURE ON FILE

Name: _____ Medicare #: _____

Address: _____

Phone Number: _____

I request that payment of authorized Medicare benefits be made to Allied Orthotics & Prosthetics on my behalf for any services furnished to me by Allied Orthotics & Prosthetics. I authorize any medical information about me to be released to the Health Care Financing Administration and it's agent to determine payable benefits for related services.

X

SIGNATURE DATE:

MEDIGAP SIGNATURE ON FILE

Name: _____ Social Security #: _____

Medigap Policy #: _____

I request that payment of authorized Medigap benefits be made to Allied Orthotics & Prosthetics on my behalf for any services furnished to me by Allied Orthotics & Prosthetics. I authorize any medical information about me to be released to the Health Care Financing Administration and it's agent to determine payable benefits for related services.

X

SIGNATURE DATE: