Anniston Orthopaedic Associates, P.A.

AUTHORIZATION FORM

731 Leighton Ave., Suite 300
Anniston, AL 36207
256-236-4121
256-237-5254 - Fax

J.R. Payne, M.D.
K.L. Vandervoort, M.D.
D.D.Tippets, M.D.
G.T. Hardy, M.D.
M.R. Wiedmer, M.D.
C.H. McCrimmon, M.D.
D.M. Tippets, D.O.
J.D. Cobb, M.D.

Patient Name_____

Complete this Section if you have Medicare.

MEDICARE PART B

Extended Patient Signature Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Anniston Orthopaedics Associates, P.A. (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____ _____

Signature of Beneficiary or person signing for Beneficiary — Date Signed

Complete this Section if you have Medicaid.

MEDICAID AUTHORIZATION ASSIGNMENT

Authorization and Assignment

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Alabama Medical Services Administration, and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the Alabama Medical Services Administration all claims against third parties, including tortfeasors and insurance companies, who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid. I also assign all rights in any settlement made by me and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid, whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Alabama Medical Services Administration. I permit a copy of this Authorization and Assignment to be used in place of the original.

_____ _____

SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS UNDER 19) — Date Signed