MEDICARE AUTHORIZATION
(**SIGN ONLY IF** Medicare is your primary or secondary insurance)

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Apple Hill Eye Center for any services furnished to me by the physicians of Apple Hill Eye Center. I authorize any holder of medical information about me to release to the center for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services."

_____ _____
Signature of Subscriber **Date of Signature**

MEDIGAP AUTHORIZATION
(**SIGN ONLY IF** you have a secondary payor after Medicare)

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to Apple Hill Eye Center for any services furnished to me by the physicians of Apple Hill Eye Center. I authorize any holder of Medicare information about me to release to _____ any information needed to determine these benefits payable for related services."

_____ _____
Signature of Subscriber **Date of Signature**