

**Chesterfield Family Practice Center, P. C.**  
**2500 Pocoshock Place, Suite 104**  
**Richmond, Virginia 23235**  
**804-276-9305**

**MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION**

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Name of Patient

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Medicare Number

I request that payment of authorized Medicare benefits be made on my behalf to Chesterfield Family Practice, P. C. for any services furnished me by that 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 or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Patient Signature

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Date