

*Yardley
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MEDICARE HEALTH INSURANCE FORM

Patient (Beneficiary): _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Yardley Dermatology Associates for any services furnished to me by Yardley Dermatology Associates. 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 for related service.

Patient (Beneficiary): _____ Date: _____