EAR SPECIALISTS
OF OMAHA

One-Time Authorization

Name of Beneficiary _____ HI Claim Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Thedinger for any services furnished to 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 for related services.

_____ _____

Patient's Signature Date Signed

Medigap Authorization Form

I hereby authorize payment of my Medigap benefits to Dr. Thedinger for all claims filed on my behalf. This authorization applies to all services until it is revoked by my representative or me.

Beneficiary Signature: _____

Medicare Number: _____

Medigap Insurer: _____

Telephone Number: _____

Medicare Secondary Payer Questionnaire
(To Be Completed For All Medicare Patients)

Name: _____

Date of Service: _____

(If any answers to questions 1a. through 4. is "yes," the corresponding section of the "Other Insurance" form must be filled out completely.)

	YES	NO
1. Are you a veteran?	_____	_____
a. Did the VA refer you here for treatment?	_____	_____
b. Do you have a VA fee-basis ID card?	_____	_____
2. Do you have a federal black lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If "yes," was it: Work Related ☐ Auto ☐ Injured in a Home ☐ Other ☐

4. Are you covered by an employer's health insurance plan through your own employment or that of a family member? (Not retiree coverage)	_____	_____

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