Center For Skin Surgery
Skin Cancer Outpatient Surgical Hospital

MEDICARE SUBSCRIBERS

"I request that payment of authorized Medicare benefits be made on my behalf to Dr. Rotter for any services furnished to me by Dr. Rotter. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I also realize if there is another insurance company I am required to furnish this information for billing purposes. If Medicare is my primary insurance carrier, Dr. Rotter accepts assignment and I will be billed according to the regulations set by the Health Care Finance Administration."

__________________________________ __________________
Signature of Beneficiary Date

SECOND INSURANCE CARRIER

"I request that payment of authorized benefits be made on my behalf to Dr. Rotter for any services furnished to me by Dr. Rotter. I authorize any holder of Medicare information about me to release to the above named insurance company any information needed to determine these benefits payable for these or related services.

__________________________________ __________________
Signature of Beneficiary Date