RENAL PHYSICIANS, INC.
MEDICARE 'SIGNATURE ON FILE'

Signing this form allows RENAL PHYSICIANS, INC. to directly receive payment from Medicare for services provided to you.

Name of Patient:_____

Medicare Number:_____

I request payment of authorized Medicare benefits be made on my behalf of Renal Physicians, Inc. for any services furnished to me by Renal Physicians, Inc. I authorize Renal Physicians, Inc. to release to the Centers for Medicare and Medicaid and its agents any medical information needed to determine my 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. My signature authorizes the release of information to the Centers for Medicare and Medicaid and payment of services to Renal Physicians, Inc. directly. Renal Physicians, Inc. accepts Medicare assignment. This means the physician agrees to accept the amount Medicare has allowed for the service provided. You are responsible for payment of the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon you agreement with Medicare.

Beneficiary Signature:_____Date:_____

Signature of Witness:_____Date:_____