LIFETIME AUTHORIZATION Date: _____

1. _____ PATIENT'S SIGNATURE

2. _____ PATIENT'S NAME (Please Print)

3. _____ PATIENT'S MEDICARE NUMBER

4. PROVIDER, ADDRESS, & ZIP

□ Clearview Eye and Laser, PLLC
7520 35th Ave SW
Seattle, WA 98126
Phone: (206) 937-9600

□ Clearview Eye and Laser, PLLC
14212 Ambaum Blvd SW, STE 100
Burien, WA 98166
Phone: (206) 431-9600

I request that payment of authorized Medicare benefits be made on my behalf to (provider listed in #4) for any services furnished me by the listed provider/supplier. 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.

LIFETIME AUTHORIZATION

I understand my signature (line #1) request that Payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA- 1500 claim form, or elsewhere on other approved claim form or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.