THE EYE CLINIC

F. PAYDAR, M.D.

Board Certified Ophthalmologist

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MEDICARE AUTHORIZATION

*To be completed if **Medicare** is the Primary Insurance*

Patient Name: ______________________________

I request that payment under The Medical Insurance Program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization. I authorize the above-named provider to release to the Social Security Administration or Intermediaries or Carries any information needed for this claim or a related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

REFRACTION EXAM:

Medicare requires that we inform you when we perform a procedure that they do not cover. Medicare along with most major insurances do not cover a Refraction. A Refraction is the portion of the exam which determines the prescription for the eyeglasses or whether you need a change in your glasses. With this notification you are aware that you be responsible for the Refraction Fee in the amount of $40.00 at the time of service.

____________________________________ ________________________

Signature Date