CHRISTOPHER N. SPELLMAN M.D., INC.
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MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Christopher N. Spellman, M.D., Inc. for services furnished me by Christopher N. Spellman, M.D., Inc.. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on approved claim forms, my signature authorizes releasing the information to the Insurer or agency shown. Christopher N. Spellman, M.D. Inc. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Print Name: _____

Authorized Signature: _____

Date: _____