QUINLAN
EYE SURGERY
& LASER CENTER

Medicare Lifetime Authorization

_____ _____

Beneficiary's Name Medicare Number

I request payment of authorized Medicare benefits be made on my behalf to Dr. Gregory H. Quinlan, D.O./Quinlan Eye Center/Quinlan Eye Surgery & Laser Center/Pittsburg Cataract Center for services furnished to me by Dr. Gregory H. Quinlan, D.O./Quinlan Eye Center/Quinlan Eye Surgery & Laser Center/Pittsburg Cataract Center. I authorize any holder of medical information about me to release HCFA and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for the deductible, co insurance and non-covered services. Coinsurance and deductible are based upon the change determination of the Medicare carrier.

_____ _____

Beneficiary's Signature or Authorized Party Date