Drs. Maklansky. Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky, Mester and Mecca
New York Medical Imaging Associates, PC
Tel: 212.535.9770 ● Fax: 212.988.1520
165 East 84th Street ● New York,NY ● 10028
www.NYMIassociates.com

MEDICARE ASSIGNMENT OF BENEFITS

_____ _____
Name of Patient: Medicare ID Number:

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to:
NEW YORK MEDICAL IMAGING ASSOCIATES P.C. for any services furnished to me.

I authorize any holder of medical information about me to release to the Health Care Finance Administration (HCFA) and my Medigap Health Insurer (if applicable) and its agents any information needed to determine these benefits or the benefits payable for related services.

This assignment shall serve as a lifetime assignment, unless otherwise requested by the above named beneficiary.

_____ _____
Patient's Signature Date

[Type text]