Jan David Tepper, D.P.M., Inc.

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Jan D. Tepper, DPM for any services furnished me by the listed Physician/Supplier. I authorize any holder of Medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap Insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms 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.

Patient's Name	Patient's Signature

Patient's Medicare Number

Provider's Name
Jan David Tepper, DPM

Address
984 West Foothill Blvd. Suite B

City	State	Zip
Upland	**California**	**91786**

Name of Medigap Insurer

Medigap Policy Number