## Payment Authorization

I request that payment of authorized Medicare/ commercial insurance benefits be made either to me or on my behalf to **HIGH ST DISCOUNT PHARMACY** for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the payable for related services.

Patient Signature_____
(Please print name & sign above)

Date_____

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## Medigap Authorization

I request that payment of authorized Medigap benefits be made either to me or on my behalf to _____ for any services furnished to me by the provider of service. I authorize any holder of Medicare information about me to release to

_____
**(NAME OF MEDIGAP INSURANCE)**

any information needed to determine these benefits for related services.

_____
**PATIENT'S SIGNATURE**

**Date:**_____