dermatology associates OF LINCOLN

6969 South St | Lincoln, NE 68506 | 402-413-7460
Casey D Bowen, MD ● Gina L Weir, MD ● Jay Arthur, PA-C ● Christina Meyer, PA-C ● Meredith McManaman, PA-C

Medicare One Time Authorization

Instructions: *This form must be signed and stored in the chart of every patient who has Medicare coverage. Once this form is signed, it does not need to be updated.*

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the rendering provider of Dermatology Associates of Lincoln, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medicare Advantage Plan benefits be made either to me or on my behalf to the rendering provider of Dermatology Associates of Lincoln, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company any information needed to determine those benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering provider of Dermatology Associates of Lincoln, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company any information needed to determine those benefits or the benefits payable for related services.

This authorization applies to all services until it is revoked by me or my representative.

By signing below, I am (i) authorizing medical information about me to be released to the Center for Medicare & Medicaid Services and its agents (ii) authorizing medical information about me to be released to my Medicare Advantage Plan insurance carrier to determine benefits payable for related services received, and (iii) authorizing medical information about me to be released to my Medigap insurance carrier to determine benefits payable for related services received.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____ _____

Patient Name (Printed) **Legal Guardian Name (Printed)** **Relationship to Patient**

Updated on 4/11/2025