Signature On File Form

1. (12 on HCFA-1500 Form) PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED_____

DATE_____

2. (13 on HCFA-1500 Form) INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED_____

3620 Harlem Road, Suite 2 * Cheektowaga, NY 14215 * Phone (716) 446-9500 * Fax (716) 446-9501