

Amar J. Sharma, M.D., F.A.A.A.I.
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ALLERGY & CLINICAL IMMUNOLOGY

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MEDICARE PATIENTS ONLY - MEDICARE RELEASE REQUEST

I hereby authorize and request Medicare to pay directly to Amar J. Sharma, M.D. the amount due me in my pending claim for basic medical, surgical treatment for services rendered. I also authorize Amar J. Sharma, M.D. to release to Medicare information about the diagnosis and treatment of my illness.

Patient's Signature _____

Date _____

MEDICARE PATIENT'S ONLY - MEDIGAP/SUPPLEMENTAL RELEASE REQUEST

I request that payment of authorized Medigap/Supplemental benefits be made on my behalf to Amar J. Sharma, M.D. for any service furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap/Supplemental insurer any information needed to determine these benefits payable for related services.

Patient's Signature _____

Date _____