Cumberland Family Medicine LLC
1203 N. High Street Suite A
Millville NJ 08332

Please read and sign the appropriate section.

Medicare / Medicaid Patient Release

I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, it's intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare or Medicaid for payment on me.

I request that payment under the medical insurance program be made either to me or Cumberland Family Medicine LLC on any bills for services furnished me by their practice.

Signature _____ Date_____

Or this

Commercial Insurance Patient Release

I hereby authorize Cumberland Family Medicine LLC to submit a claim to my insurance carrier or it's intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or it's intermediaries to issue payment directly to the physician(s) rendering the covered services.

I authorize Cumberland Family Medicine LLC to furnish complete information to my insurance carrier or it's intermediaries regarding services rendered.

Signature _____ Date _____