Bio-Magnetic

MRI/MRA Imaging Centers

Bio-Magnetic Resonance, Inc.
30781 Stephenson Highway
MADISON HEIGHTS, MI 48071
(248) 585-5115
FAX (248) 585-0234

The Imaging Center
15670 Southfield Road
ALLEN PARK, MI 48101
(313) 294-2897
FAX (313) 294-2915

Bio-Magnetic Resonance, Inc.
25100 Kelly Road
ROSEVILLE, MI 48066
(586) 445-4900
FAX (586) 445-4902

Biomagnetic Imaging Center
960 River Centre Drive
PORT HURON, MI 48060
(810) 966-8523
FAX (810) 966-5056

The Imaging Center
4447 Talmadge, Suite H
TOLEDO, OH 43623
(888) 674-8653
FAX (888) 674-8650

(888) MRI-TODAY
(674-8632)
www.biomagmri.com
Rev. 4-6-09

LOCATION: _____

MEDICARE PATIENT AUTHORIZATION FORM

"I request that payment of authorized Medicare Benefits be made on my behalf to Bio-Magnetic MRI/MRA Imaging Centers for any services furnished to me by this provider."

_____
Patient's Full Name (as it appears on card)

_____
HIC Claim Number

Marital Status:

Married _____ **Divorced** _____

Widowed _____ **Single** _____

For services furnished to in-patients of a hospital or SNF, this request is effective for the period of confinement. For services furnished by a provider/supplier or on an outpatient basis, this request is effective until revoked by the beneficiary.

"I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance to the party who accepts assignments."

_____ _____
Patient Signature **Date**