AESTIQUE PLASTIC SURGICAL ASSOCIATES, Ltd.

STATEMENT TO PERMIT MEDICARE BENEFITS TO PROVIDER

Name of Beneficiary_____ HIC#_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Aestique Plastic Surgical Associates, Ltd. for any services furnished to me by Theodore A. Lazzaro, DMD, Maria Sidoni, NP-C, Nadine O. Custer, PA or any Aestique Plastic Surgical Associate Ltd provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Beneficiary Signature_____ Date_____

STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER

Name of Beneficiary_____ HIC#_____

Medigap Policy Number_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Aestique Plastic Surgical Associates, Ltd., for any services furnished to me by Theodore A. Lazzaro, DMD, MD, Maria Sidoni, NP-C, Nadine O. Custer, PA or any Aestique Plastic Surgical Associate Ltd provider. I authorize any holder of Medicare information about me to release to _____(Name of Medigap insurer) any information needed to determine these benefits payable for related services.

Beneficiary Signature_____ Date_____