RADIATION ONCOLOGY ASSOCIATES, P.C.
DOCTORS TONNESEN BOYLAN HETELEKIDIS KANANI BAJAJ CHAWLA
PO BOX 8560
RICHMOND, VA 23226-0560
(703) 996-4887 OR (800) 843 5258

PATIENT AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO RADIATION ONCOLOGY ASSOCIATES, P.C.

I, _____ , hereby authorize Radiation Oncology Associates, P.C. to apply for benefits on my behalf for covered services rendered by either Glenn L. Tonnesen, M.D., Susan E. Boylan, M.D., Stella Hetelekidis, M.D., Samir P. Kanani, M.D., Gopal K. Bajaj, M.D., Ashish Chawla, M.D. I request payment from Medicare, and /or _____ be made directly to Radiation Oncology Associates, P.C.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) when claim involves Medicare Part B; and/or

_____
(other insurance company)

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or the above named carrier at any time in writing.

_____
(Signature of Subscriber or Patient) (Identification #) (Date)