Erie Audiology INC.

Allison F. Keenan, Au.D., F.A.A.A.
Doctor of Audiology

2550 West 8th Street, Erie PA 16505
814/833-9533 • Fax 814/833-1621

Name _____ Claim # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Erie Audiology for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature _____ Date _____

Name _____ ID # _____

I request that payment of my authorized insurance benefits (ex: Highmark, AARP, United Health, etc.)be made either to me or on my behalf to Erie Audiology for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of this insurance information about mé to release to _____ any information needed to determine these benefits or the benefits payable for related service.

Signature _____ Date _____