REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

(See Instructions on Back-Type or Print Information)

Form Approved
Budget Bureau No.

				The second secon		72-RO	730	
PART I-PATIENT TO FILL IN TIEMS IL THROUGH 6 ONLY								
Medicare Division Pan-American Life Insurance Co. P.O. Box 60450 New Orleans, Louisiana 70160			Copy from your HEALTH INSURANCE CARD	Name of patient ARTHUR J. DUCOING				
			(See example on back)	Health insurance claim number 433 01 5031 A		Male ☐ Female		
Patient's street address City, State, ZIP code				e		Telephone Number		
101	6 FLYSTAN	FIELDS AVE	5 LA 70117	LA 70117		943-5982		
Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)						Was your illness or injury connected with your employment?		
						☐ Yes ※ No		
If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you wan information about this claim released to the insurance company or State agency upon its request, give the following information.								
Insuri	Insuring organization or State agency name and address Policy or Medical Assistance Number							
I authorize any holder of medical or other information about me to release to the Social Security 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 benefits either to myself or to the party who accepts assignment below.								
Signature of patient (See instructions on reverse where patient is unable to sign)						Date signed		
SIGN Darthur J. Ducoing						6/10/69		
	Section 2015	PART III—PHYSIC	ANEOR SUPPLIES	TO HEL IN 7 PAROL	GHIA			
7 A. Data of each service	B. Place of service (*See Codes below)	C. Code surgical or medical properties or supplies for each date gives	D. Nature of illness or injury requiring services or supplies		E. Charges (if re- lated to unusual circumstances explain in 7C)	Leave Blank		
) deceneral mellites		\$		
8 Name and address of physician or supplier (Number and street, city, State, ZIP code) 403 MEDICAL ARTS BLDG.				Telephone No.	9 Total charges	\$ 101		
3439 PRYTANIA ST NEW ORLEANS, LA. 70115				Physician or	10 Amount paid	\$ 101		
PHONE; 895-6679				supplier code	11 Any unpaid balance due	\$		
12 Assignment of patient's bill 13 Show name and address of facility where services were performed (If other than home or office visits)								
☐ I accept assignment ☐ I do not accept assignment								
14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction) Other degree — Do Dos Date signed Other degree — Dos Dos Date signed								
*O-Doctor's Office H-Patient's Home (If portable X-ray services, identify the supplier) ECF-Extended Care Facility OL-Other Locations								