



**Drs. Maklansky, Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky**

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**MEDICARE ASSIGNMENT OF BENEFITS**

Name of Beneficiary: .....

Insurance ID#: .....

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to the Maklansky, Grunther, Kurzban, Cohen, Zimmer, Hyman & Berson M.D., P.C., for any services furnished me by the MGKCZHB, M.D., P.C., and it's physicians.

I authorize any holder of medical information about me to release to the Health Care Finance Administration (HCFA) and my Medigap Health Insurer (if applicable) and its agents any information needed to determine these benefits or the benefits payable for related services.

This assignment shall serve as a lifetime assignment, unless otherwise requested by the above named beneficiary.

Beneficiary Signature: .....

Date signed:.....

Daniel Maklansky, M.D.  
Alain D. Hyman, M.D.

Jerold Kurzban, M.D.  
Barry D. Berson, M.D.

Burton A. Cohen, M.D.  
Joseph J. Maklansky, M.D.

Jerald Zimmer, M.D.  
Jolinda Mester, M.D.

CT64 \* MRI \* CT AND MR ANGIOGRAPHY \* PET/CT \* CT CORONARY \* CT LUNG SCREENING \* ULTRASOUND/VASCULAR DOPPLER \* DEXA \* DIGITAL MAMMOGRAPHY \* BREAST IMAGING \* FLUOROSCOPY \* SCINTIGRAPHY \* X-RAY