MEDICARE/TRICARE DENIAL FORM

I am seeking medical care from FirstCare Medical Centers, LLC.

I understand that by signing this form, I am denying that I have **Medicare Part B** or **Tricare** coverage.

I understand that I am financially responsible for this account and that I am expected to pay in full at the time services are rendered.

Date: _____

Signature: _____

Printed Name: _____

1301 Huffman Road, Suite 205, Anchorage, AK 99515-3568 * Business Office (907) 345-2050
Spenard (907) 248-1122 * Huffman (907) 345-1199