MOUNT PLEASANT
MEDICAL ASSOCIATES

CHAMPUS/TRICARE INSURANCE COVERAGE

I request that payment of authorized benefits be made either to me or on my behalf to MPMA for any services furnished to me by MPMA, including physician services. I authorize any holder of medical information about me to release to CHAMPUS and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature Date of Service