MEDICARE BENEFICIARY AUTHORIZATIONS

Name of Beneficiary _____ Medicare No. _____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services."

_____ _____

Beneficiary Signature Date

MEDIGAP

(Medicare Patients Only)

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to _____ for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to _____ (carrier name) any information needed to determine these benefits payable for related services.

_____ _____

Beneficiary Signature Date

RELEASE OF MEDICAL BENEFITS AND RECORDS

Name of Patient _____ Claim No. _____

"I authorize payment of Medical benefits to _____ for services rendered. I understand that services are rendered to me and not to insurance carrier on my behalf. The insurance carrier will not relieve me from my financial responsibility to _____ I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

_____ _____

Signature of Responsible Party Date