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NAME _____

DATE OF BIRTH _____

DATE ___ / ___ / ___

*I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician.

SIGNED _____

I request that payment of authorized Medicare benefits by made either to me or on my behalf to the name of the provider of the service and (or) supplier for any services furnished to me by that provider of service.

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 benefits payable for related services.

I request that payment of authorized Medigap benefits be made whether to me or on my behalf to the provider of the service and (or) supplier for any services furnished to me by that provider of service and (or) supplier.

I authorize any holder of Medicare information about me to release to my Medigap Insurer any information needed to determine these benefits payable for related services.

NAME _____ DATE _____

SIGNATURE _____