PATIENT INFORMATION

NAME: ____

MEDICARE # ____________________ **MEDICAID #** ____________________ **STATE** __________

MEDICARE PATIENTS ONLY

MEDICARE
LIFETIME BENEFICIARY CLAIM AUTHORIZATION

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

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated on approved claim forms or electronically submitted claims, my signature authorizes the releasing of information to the insurer or agency shown.

I authorize Orthopedic Institute to appeal Medicare claims on my behalf.

Signed ________________________ Signed ________________________ Date __________