

FOR OUR MEDICARE PATIENTS:

Name of Beneficiary: _____

Medicare policy number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Shoulder Clinic of Idaho for any services furnished me by the providers of The Shoulder Clinic of Idaho. I authorize any holder of medical information about me to release to the Centers Of Medicare & Medicaid Services, formerly the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date: _____ Signature: _____

Secondary Insurer & policy number: _____

I request that payment of authorized Medigap benefits be made on my behalf to The Shoulder Clinic of Idaho for any services furnished me by them. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits.

Date: _____ Signature: _____