MEDICARE AUTHORIZATION and ASSIGNMENT

PATIENT NAME: _____MEDICARE ID: _____

SIGNATURE: _____

CLINICAL STAFF WITNESS: _____

DATE: _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I authorize any holder of Medical or other information about me to release to the SSA or its intermediaries or carriers any information needed for this or a related Medicare Claim.

I request that payment or authorized benefits be made either to me or on my behalf.

MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C.