Name: _____
DOB: _____
Chart: _____
Date: _____

#

ONE TIME AUTHORIZATION

Approved Form No: OMB No. 0938-0222

NAME OF PATIENT **MEDICARE ID NUMBER**

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr._____Midwest Orthopaedics, P.A._____for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE **DATE SIGNED**

DO NOT MAIN THIS FORM IN - RETAIN IN PATIENT'S FILE IN YOUR OFFICE

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