

## AUTHORIZATION TO RELEASE INFORMATION TO MEDICARE

***This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:***

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

\_\_\_\_\_  
*Signature as it appears on Medicare Card*

\_\_\_\_\_  
*Date*

## AUTHORIZATION TO RELEASE INFORMATION TO MEDIGAP

***If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier auto-matically "crosses over," we are required to keep a separate signature on file:***

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
*Signature as it appears on Medigap Card*

\_\_\_\_\_  
*Date*

***Answer questions below by placing a check in the appropriate column.***

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you recently joined a <b>MEDICARE ADVANTAGE PROGRAM OR HMO?</b><br>If yes, identify: _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by an HMO/PPO which makes Medicare secondary?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness covered by the VA (Veteran's Administration)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness due to an automobile accident?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness due to an injury at work?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you receiving Medicaid?   |