MEDICARE BENEFICIARY AUTHORIZATIONS

Name of Beneficiary	A STATE OF THE STA	Medicare No.	The second secon
I request that payment of	authorized Medicare benefits be mad	le either to me or c	on mv
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eneficiary Signature		Date	
	MEDIGAP		
	(Medicare Patients Only)		
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request that payment of a	uthorized Medigap benefits be made	either to me or or	a muchaha
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eficiary Signature		Date	maj a plantenium e 1880 g. 1880 g. m. neprenium principalis de l'enforcement de l'éche par
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HELEASE OF	MEDICAL BENEFITS A	IND RECOR	IDS
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authorize payment of Med		topographic programmer many many many many many many many many	
services rendered. I under rier on my behalf. The ins	erstand that services are rendered to surance carrier will not relieve me fro	me and not to insi m my financial res	urance ponsibility
ereby authorize said assig d benefits.	nee to release all information neces	sary to secure pay	ment of
ature of Responsible Party		Data	