

Medicare Patient Information

Patient Name: _____ SSN: _____

Date of Birth: ____/____/____ Sex: Female Male

Address: _____
Street

City State Zip Code
() _____ () _____
Home Phone Work Phone

Please print your name as it appears on your Medicare card

Medicare Health Insurance Claim Number as it appears on your card. This is usually your Social Security number. Be sure to include the letter after the nine-digit number. It is important that we have both the numbers and letter

Referring Physician

Name: _____ Phone# () _____

Emergency Contact

Name of Spouse or Close Relative or Friend: _____
(In Case of Emergency)

Phone# () _____

Please Sign So We May Have Your Medicare Authorization On File

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.

Date: ____/____/____ Signature: _____

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