

MEDICARE BENEFICIARY SIGNATURE ON FILE

Name of Beneficiary: _____

Medicare Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Southern Illinois Pain Management** for any services furnished to me by the physician/physician assistant. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature

Date

Name of beneficiary _____ Medicare Number _____

Medigap Policy Number _____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to **Southern Illinois Pain Management** for any services furnished to be by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

Signature

Date