MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to _____
Doctor/Supplier
for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

BENFICIARY SIGNATURE: _____

MEDICARE NUMBER: _____

MEDIGAP INSURER: _____

ADDRESS: _____

_____

_____

TELEPHONE NUMBER: _____

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