ONE TIME AUTHORIZATION

Approved Form No: OMB No. 0938-0222

NAME OF BENEFICIARY **HEALTH INSURANCE CLAIM NUMBER (HIC)**

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. ______________________________________ for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________________ ______________________

PATIENT'S SIGNATURE **DATE SIGNED**

37-260 10/82

DO NOT MAIL THIS FORM IN – RETAIN IN PATIENT'S FILE IN YOUR OFFICE.