

# FAMILY RESOURCES ASSOCIATES, INC.

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## PATIENT SIGNATURE ON FILE FOR MEDICARE CLAIMS

Entitlee's Name: \_\_\_\_\_  
Last First Middle Initial

H.I. Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Letter

I request that payment of authorized Medicare benefits be made either to me or on my behalf to

\_\_\_\_\_  
(Name of physician, clinic, etc.)

for any services furnished me by that provider. 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.

This authorization is in effect until I choose to revoke it. \*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\*If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.