

****ALL SECTIONS REQUIRED**
Medicare Authorization Form

Section A: Beneficiary Information

Name (As it appears on Medicare card):

Date of Birth:

Medicare ID Number:

Address:

City:

State:

ZIP Code:

Section B: Record Time Frame Definition

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** item: Release **all** records OR Timeframe of claim records from start date _____ to end date: ____
NY RESIDENTS MUST ALSO SELECT: Release **all** records OR Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Identify a future date or event when the authorization will expire (one time disclosure if no date or event provided).

Specified Date _____ OR Event _____

Section C: Release Information To

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

1. Organization/Individual Name and Contact:

Organization/Individual Mailing Address:

2. Organization/Individual Name and Contact:

Organization/Individual Mailing Address:

Section D: Purpose for Request

This section helps Medicare understand the reason or intent for use for this record request.

At the request of the individual

Litigation

Section E: Authorization Agreement

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law:

Date Signed:

X _____

Legal Role of Representative (Requires Additional Documentation):

****ALL SECTIONS REQUIRED
Medicare Authorization Form**

Section A: Beneficiary Information
 Name (As it appears on Medicare card): _____ Medicare ID Number: _____
 Date of Birth: _____ State: _____
 Address: _____ ZIP Code: _____
 City: _____

Section B: Record Time Frame Definition
 Medicare will only disclose the claim information identified below for the individual in Section A.
 Select one item: Release all records OR Timeframe of claim records from start date _____ to end date: _____
NY RESIDENTS MUST ALSO SELECT: Release all records OR Exclude information about alcohol and drug abuse, mental health treatment, and HIV
 Specify a future date or event when the authorization will expire (one time disclosure if no date or event provided)
 Specified Date _____ OR Event _____

Section C: Release Information To
 Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.
 1. Organization/Individual Name and Contact: _____
 Organization/Individual Mailing Address: _____
 2. Organization/Individual Name and Contact: _____
 Organization/Individual Mailing Address: _____

Section D: Purpose for Request
 This section helps Medicare understand the reason or intent for use for this record request.
 At the request of the individual Litigation

Section E: Authorization Agreement
 I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.
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 I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.
 Signature of Beneficiary or Representative Authorized by Law: _____ Date Signed: _____
 Legal Role of Representative (Requires Additional Documentation): _____

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| <p>1 BENEFICIARY NAME & MEDICARE NUMBER
As it appears on the Medicare Card</p> <p>2 RECORD TIMEFRAME
Select date range if not selecting "ALL RECORDS"

NY Residents-additional required selection</p> <p>3 SELECT EXPIRATION DATE
If specific date or event required</p> <p>4 SPECIFY ORGANIZATION TO RELEASE TO
Must include contact first and last name and address</p> | <p>5 SELECT REASON FOR REQUEST
This includes litigation and "by request of the individual"</p> <p>6 REQUIRED AUTHORIZATION CLAUSES
HIPAA clauses required to release information</p> <p>7 BENEFICIARY SIGNATURE
Signed and dated by beneficiary or authorized representative (If not signed by beneficiary; note that POA or Letters Testamentary are required)</p> |
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