STATEMENT TO AUTHORIZE MEDICARE PARTICIPATING PROVIDERS TO REQUEST MEDICARE TO SEND PAYMENT INFORMATION AND TO RECEIVE THE BENEFICIARY PAYMENTS FROM THE MEDIGAP INSURANCE COMPANIES

Name of Beneficiary _____

Health Insurance Claim Number _____

I authorize Medicare to send "Explanation of Your Medicare Part B Benefits" information to my Medigap Insurance and benefits to be made in my behalf to Basin Vision Center, P.C. for any services furnished to me by this Medicare Participating Provider until further notice. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration or its agents.

Medigap Insurer _____

Patient's Signature _____

Date _____