

**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 on 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 Centers for Medicare & Medicaid Services or its agents.

Medigap Insurer _____

Patient's Signature _____

Date _____