

MEDICARE LIFETIME AUTHORIZATION

PATIENT'S NAME _____

MEDICARE
ID# _____

I request that payment under the medical insurance program be mad either to me or to Surgical Associates to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Authorization period:

From: _____ To: Lifetime