RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR MEDICARE BENEFICIARIES

I hereby assign Medicare benefits to San Carlos Apache Healthcare Corporation for medical and prescription services furnished to me by these facilities. I authorize direct billing to Medicare. I authorize any holder of medical and other information about me to be released to Medicare and its agents to determine Medicare benefits related to medical and prescription services.

Date of Birth: _____ HR: _____

_____ _____
Signature of Beneficiary or Authorized Representative Date

_____ _____
Signature of Patient Financial Service Representative Date

( ) I bear witness that this patient was unable to sign this form, and, a surrogate was not appointed and/or available to sign for the named patient.

_____ _____
Witness Signature and Title as applicable Date

Beneficiary Printed Name: _____

Medicare Number: _____

Part A Effective Date: _____

Part B Effective Date: _____

Part D Plan Name: _____ Effective Date: _____

Part D Plan ID Number: _____

AHCCCS coverage: ***Please circle*** *QMB SLMB QI-1* Effective Date: _____

FORM MUST BE COMPLETED EVERY CALENDAR YEAR