Southwest CVA
Cardiovascular Associates

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06 - MEDICARE AUTHORIZATION

PATIENT NAME: _____

MEDICARE POLICY ID #: _____ **DATE OF BIRTH:** _____

AUTHORIZATION

***FROM:** _____ ***TO:** _____
Today's Date ***+1 Year***
*(*or until rescinded)*

†By signing my name below, I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization.

I also authorize the above named provider 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.

PATIENT SIGNATURE: † _____ **DATE:** _____

Please Note: ***This form is totally confidential and will be used solely for the intended purpose outlined above. All information on this form is protected by the Health Insurance Portability and Accountability Act (HIPAA) and, as such, the use of this form will only be conducted within its guidelines.***

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