FAMILY RESOURCES ASSOCIATES, INC.

1315 West Main Street
Watertown, WI 53094
(920) 261-4100

Fax (920) 261-8801

www.familyresourcesinc.com

331 North Main Street
Lake Mills, WI 53551
(920) 648-3896

PATIENT SIGNATURE ON FILE FOR MEDICARE CLAIMS

Entitlee's Name:_____
Last First Middle Initial

H.I. Number:_____-_____-_____ _____
Letter

I request that payment of authorized Medicare benefits be made either to me or on my behalf to

_____
(Name of physician, clinic, etc.)

for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it. *

Signed:_____Date:_____

*If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.