LIFETIME MEDICARE AUTHORIZATION FOR PAYMENT

Patient Name: _____

Patient's Medicare Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to:

Colorado Springs Orthopaedic Group

for any medical services furnished me by the above physician group.

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.

Patient Signature: _____ Date: _____