MEDICARE COMPLIANCE FORM

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare/Medigap benefits be made to me or on my behalf to Morgan Kalman Clinic for any services rendered to me by Morgan Kalman Clinic. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

In compliance with Medicare regulation, we are required to ask the following questions:

Currently, do you or your spouse work for a company that provides either of you health insurance? ❑ Yes ❑ No

Are you entitled to Medicare because of disability or end stage renal disease? ❑ Yes ❑ No

Is the illness or injury the result of an automobile accident or other injury? ❑ Yes ❑ No

Has your treatment for the accident or illness been authorized by the Veterans Administration: ❑ Yes ❑ No

Are you entitled to any benefits under the Federal Black Lung Program? ❑ Yes ❑ No

I certify that this information is true and complete to the best of my knowledge.

Signature _____ Date_____