

Foster Health & Wellness Center, PLLC
2051 Terry Street, Suite B, Longmont, CO 80501
303/702-0975 FAX 303/772-4046

MEDICARE
Authorization for Payment

Name of Patient _____ Patient # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for services furnished me by that physician.

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 payable for related services.

Signature of Patient

Date