MEDICARE BENEFICIARY AUTHORIZATION FORM

To Whom it May Concern:

In cases requiring disclosure of Medicare information to someone other than the beneficiary, the following authorization must be completed and returned to our office.

1. The beneficiary's complete name. Date of Birth

   _____ _____/_____/_____

2. The beneficiary's Medicare number including the letter suffix.

   _____

3. The name of the specific individual, (example, family member or friends) to whom the information may be disclosed along with a telephone number.

   c/o Macro-Pro, Inc. Ph#: 800-696-2511

4. I authorize Macro-Pro, Inc. to inquire and receive information on the following: (Check one or more)

   ☐ One service only. ☐ Date of service: _____
   Doctor/supplier: _____
   ☐ All services: _____
   ☐ All services from (doctor or supplier): _____
   ☐ Medicare eligibility information
   ☐ Information on other health coverages: _____
   ☐ Deductible information for (year): _____

5. Please explain the information or question you would like released immediately, otherwise, this form will be retained in our files for future inquiries from the above person. _____
   _____

6. The specific period of time the information may be released. Please indicate whether the consent is for an ongoing release of records or for a one-time release of records.
Ongoing_____ One – time release_____ Timeframe of the release_____
(Valid for one year only)

A blanket consent to disclose all of the beneficiary's records to unspecified individuals or organizations will not be honored. If you are signing as a Power of Attorney, please provide notarized documentation.

You have the right to take back (revoke) your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to: Medicare Part B, P.O. Box 3543, Topeka, Kansas 66601-3543

Please return this completed form to: Medicare Part B
P.O. Box 3543
Topeka, KS 66601-3543

If you have any question please call the toll free number listed below:

1-800-MEDICARE (1-800-633-4227)

I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

Your personal medical information that you authorize Medicare to disclose may be subject to re-disclosure and no longer protected by law.

***** All items on form must be completed to be valid.**

Beneficiary's Signature	Telephone Number	Date
Print Beneficiary's Name	Medicare Number	

OMB # 0938-0222
Revision Date: December 8, 2004