

**MEDICARE LIFETIME ASSIGNMENT**

Name of Beneficiary \_\_\_\_\_

Medicare Number \_\_\_\_\_

I request that payment of authorized Medical benefits be made to me or on my behalf to Emergency One for any services furnished to 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 benefits or the benefits payable for related services.

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

Signed \_\_\_\_\_ Date \_\_\_\_\_