

Hess Clinic

2201 Canterbury Drive

Hays, KS 67601

Office: (785) 628-7495

Fax: (785) 628-3262

ONE TIME AUTHORIZATION

NAME OF BENEFICIARY

HI CLAIM NUMBER

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. _____ for any 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 or the benefits payable for related services.

Patient's Signature

Date Signed

DO NOT MAIL THIS FORM IN – Retain in Patient's File in your office.