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LIFETIME INSURANCE AUTHORIZATION

AND/OR

MEDICARE CERTIFICATION

(Allows me to Bill your Insurance Company)

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for licensed clinical social work services to the licensed clinical social worker or organization furnishing the services or authorize such licensed clinical social worker or organization to submit a claim to Medicare for payment to me.

I request that this authorization also apply to all other insurance.

I authorize the licensed clinical social worker to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signed _____ Date _____

By _____

Title or Relationship _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____
