

MEDICARE PAYMENT AUTHORIZATION

BENEFICIARY _____ HICN _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **YAKIMA ORTHOTICS & PROSTHETICS, PC** for any services furnished me by that supplier. 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.

Signature _____

Date _____

ITEM _____